

Place for County Logo

Individualized Family Service Plan-IFSP  
 Individualized Educational Plan – IEP

(Please check the one(s) that apply.)

Date: \_\_\_\_\_

**Child's Legal Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
**Address of Child:** \_\_\_\_\_ **City:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

Male  Female (check one) **City of Birth:** \_\_\_\_\_ **Birth Order (if multiple)** \_\_\_\_\_  
**Child's ID#:** \_\_\_\_\_

**Ethnic Heritage:**  Hispanic or Latino  White including Middle Eastern  
 American Indian or Alaska Native  Asian American  
 Black or African American  Native Hawaiian or other Pacific Islander

**Resident ISD/RESA/RES D:** \_\_\_\_\_ **Resident Local District:** \_\_\_\_\_

Parent/Guardian Name	Relationship to Child	Native Language/ Interpreter Needed?	Phone-Day-Other/E-mail
		<input type="checkbox"/> Yes Interpreter needed	
		<input type="checkbox"/> Yes Interpreter needed	
		<input type="checkbox"/> Yes Interpreter needed	

Address if different from child: \_\_\_\_\_

**Status:**  Early On® Referral  Early On Transfer  Special Ed Referral  Special Ed Transfer  
(check all that apply)  
**Date of Referral:** \_\_\_\_\_ **Date of Transfer:** \_\_\_\_\_  
**Referral Source:** \_\_\_\_\_ **Transferred in from:** \_\_\_\_\_

**Eligibility:**  Early On  Special Education  Both  Not Eligible  
(Complete and sign the eligibility determination sheet.)

**Service Coordinator:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
**Agency:** \_\_\_\_\_ **Address:** \_\_\_\_\_

**Dates important to follow:**  
**Referral Date:** \_\_\_\_\_ **Initial IFSP Meeting Date:** \_\_\_\_\_ **Completed IFSP Date:** \_\_\_\_\_  
Day 0 Day 45- Evaluation completed Day 60- Signatures received

**Other possible agencies or programs involved with child and/or family**  
 WIC  MIHP  IMH  Early Head Start  Great Parents Great Start  Medicaid  CSHCS

Office use only  
**Justification for not completing the Initial IFSP Meeting within 45 days from the date of referral:**  
 Child unavailable  External reports not received  Family issues  Natural Disaster  Personnel unavailable  
 Other  
**Explain the justification checked:** \_\_\_\_\_

## Family Strengths, Needs, and Priorities

Child's Legal Name: \_\_\_\_\_ Person interviewed: \_\_\_\_\_ Date of interview: \_\_\_\_\_

What is your child's typical day like? Who is he/she usually with? What does he/she play with?

On most days, what part of the day is the most enjoyable? The most difficult? Why?

What people, supports or resources are helpful or would be helpful to your family? What resources do you currently have?

What are some activities you enjoy doing with your child and family? What activities are stressful?

What concerns do you have with your child?

Do you have concerns about your child's ability to: (check all that apply; then number your top priorities)

- |   |   |
|---|---|
| <input type="checkbox"/> Get around (crawl, walk, run)    | <input type="checkbox"/> Talk and listen                                      |
| <input type="checkbox"/> Think, learn, play with toys     | <input type="checkbox"/> Feed, eat  |
| <input type="checkbox"/> Have fun with other children     | <input type="checkbox"/> Relate in a meaningful way with other family members |
| <input type="checkbox"/> Bathe, undress, dress, go to bed | <input type="checkbox"/> Look at you  |
| <input type="checkbox"/> Calm down, quiet down            | <input type="checkbox"/> Sleep  |
| <input type="checkbox"/> See or hear                      | <input type="checkbox"/> Other  |

**I want to know more about:** (check all that apply)

- Meeting with other families to share information, or to learn about a child like mine.
- Finding or working with doctors or other specialists.
- Planning for the future; what to expect.
- People who can help me at home or care for my child so I/we can have a break.
- Information on my child's condition, what it means.
- Resources to help cover the costs of my child's special needs (e.g. equipment, supplies...).
- Housing, clothing, jobs, education, food, telephone.
- Other:

### Child's Current Developmental Status

Date: \_\_\_\_\_

Child's Legal Name: \_\_\_\_\_ Age: \_\_\_\_\_ Corrected Age (for premature infants): \_\_\_\_\_

Eligibility must be based on the integration of all four of the following sources of information. (Check all that have been used):

Developmental History     Health Status     Observation of Child and Parent Interaction     Developmental Evaluation

See the Integrative Report incorporating the above four sources.     Date of Multidisciplinary Evaluation: \_\_\_\_\_

Child's Current Developmental Status			
Area	Present Level of Development Parent Input	Result of Developmental Evaluation	Method/Tool/Date Person Completing the Area Name/Title
<b>Health</b> <input type="checkbox"/> See Attached Report		<input type="checkbox"/> How affects participation in Early Intervention activities	
<b>Hearing</b> <input type="checkbox"/> See Attached Report		<input type="checkbox"/> Language needs considered	
<b>Vision</b> <input type="checkbox"/> See Attached Report		<input type="checkbox"/> Braille needs considered	
<b>Fine Motor</b> <input type="checkbox"/> See Attached Report			
<b>Gross Motor</b> <input type="checkbox"/> See Attached Report			
<b>Cognitive/Thinking</b> <input type="checkbox"/> See Attached Report			
<b>Communication</b> <input type="checkbox"/> See Attached Report		<input type="checkbox"/> English proficiency considered; Sign language	
<b>Social/Emotional</b> <input type="checkbox"/> See Attached Report		<input type="checkbox"/> Positive Behavioral Supports Considered	
<b>Adaptive</b> <input type="checkbox"/> See Attached Report		<input type="checkbox"/> Assistive Technology Considered	

## Eligibility Determination

Child's Legal Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

(Check A or B)

- A.** This child meets the eligibility for early intervention services (Check all that apply)
1. A **Developmental Delay** in at least one of the following area(s): (Check all that apply)
- Gross Motor                       Fine Motor                       Communication                       Cognitive
  - Social/Emotional                       Self-Help                       Physical development including hearing & vision
2. An **Established Condition** which has a high probability of resulting in a developmental delay. (Check all that apply)
- Chromosomal/Genetic
  - Neurological Disorder
  - Congenital Malformation
  - Inborn Error of Metabolism
  - Sensory Disorder including Hearing and/or Vision Deficiencies
  - Atypical Development Disorder
  - Severe Toxic Exposure
  - Chronic Illness
  - Severe Infectious Disease
3. **Special Education** (Specify Rule Number)
- Physical Impairment Rule # 340.1709
  - Other Health Impairment Rule # 340.1709a
  - Speech and Language Impairment Rule # 340.1710
  - Hearing Impairment Rule # 340.1707
  - Vision Impairment Rule # 340.1708
  - Early Childhood Developmental Delay Rule # 340.1711
  - Severe Multiple Impairment Rule # 340.1714
  - Autism Rule # 340.1715
  - Cognitive Impairment Rule # 340.1705
  - Other: \_\_\_\_\_
  - Other: \_\_\_\_\_
- B.** This child does not meet the eligibility criteria for *Early On*.
- Offer to re-screen child within six months.
- Offer community resources that might benefit the family:
- \_\_\_\_\_
- This information was given to the family on \_\_\_\_\_.

Participants in *Early On* who found the child ineligible

	Title
	Evaluator
	Evaluator
	Service Coordinator

**Early On IFSP Outcome and/or**  **Special Education IEP Goal**

Child's Legal Name: \_\_\_\_\_ Current Date: \_\_\_\_\_

**Concern of the Parent:**

**Present Status:** (What is the child doing now? What has been tried? What is working?)

**Goal/Outcome Statement:** (What would you like to see happen for your child?)  
 The child            (audience) will            (behavior) what/at            (condition or criteria) by            (date)  
 Priority number: (Please circle) 1 2 3 4 5 6 7 (The priority number should match priorities identified on pages 2 and 3)

Goal #: \_\_\_\_\_

<b>Steps or short term objectives:</b> (At least 2 per goal)	<b>* Evaluation</b>	<b>**Criterion</b>	<b>***Timeframe</b> (needed to accomplishment this step)
1.			
2.			
3.			
4.			

**Strategies/Methods:** (What methods or techniques will be used during the child's daily routines to meet this outcome?)

**Progress Toward Outcome**

**Progress made:** (To be evaluated at least every 6 months)

Date	Obj. 1	Obj. 2	Obj. 3	Obj. 4	Comments/ Status of Progress ****

<b>* Evaluation</b>	<b>** Criterion</b>	<b>***Timeframe</b>	<b>****Status of Progress</b>
D - Documented observation P - Parent(s) report R - Rating scale A - Assessment Tool	___ % Accuracy ___ Parent Satisfaction ___ Achievement level ___ Other (specify)	- 1 month - 2 months - 3 months - 6 months - 9 months	1 – Achieved/Maintained 2 – Progressing at rate sufficient to meet goal 3 – Progressing below a rate sufficient to meet goal – needs revision 4 - Partially accomplished 5 - Other (specify)

## Early Intervention Services

Child's Legal Name: \_\_\_\_\_

Date: \_\_\_\_\_

Service / Provider	Supports Outcome(s) #	How long/How often? Method (Indiv/Group)	Location	Projected Start Date/ End Date	Parent's Initials of each service	Payor
			1. Home 2. Community Setting 3. Other			
#1			<input type="checkbox"/> Yes Justification needed			
#2			<input type="checkbox"/> Yes Justification needed			
#3			<input type="checkbox"/> Yes Justification needed			
#4			<input type="checkbox"/> Yes Justification needed			
#5			<input type="checkbox"/> Yes Justification needed			

Natural environments means settings that are natural or normal for the child's age peers who have no disabilities (34CFR 303.18). The IFSP requires a "justification of the extent, if any, to which the services will not be provided in a natural environment" (IDEA section 636(d)(5) and (303.344(d)(ii)). There must be a justification for each service not provided in the natural environment.

Justification: Service # \_\_\_\_\_

Justification: Service # \_\_\_\_\_

Justification: Service # \_\_\_\_\_

<b>Other Supports and Services</b> (Other resources, supports, services that assist the family)					
Service/Support	Supports Outcome Number	How long? How Often?	Start/End Date	Location	Funding Source

## Signature & Procedural Safeguards

(This signature page is to be used with every IFSP or IEP development or change.  
Check the "Type of IFSP/ IEP to indicate the purpose of this page.)

Child's Legal Name: \_\_\_\_\_

Date: \_\_\_\_\_

Type of IFSP or IEP	
<input type="checkbox"/> Interim IFSP/Date: _____ <input type="checkbox"/> Initial IFSP Date: _____ <input type="checkbox"/> Completed IFSP Date: _____ <input type="checkbox"/> 6 Month Review/Date: _____	<input type="checkbox"/> Annual IFSP and/or IEP/Date: _____ <input type="checkbox"/> Other Review/Date: _____ <input type="checkbox"/> Transition Conference/Date: _____ <input type="checkbox"/> Transition/Date: _____

Child Outcomes Review	
<input type="checkbox"/> <b>Entry</b> <input type="checkbox"/> <b>Annual (Optional)</b> <input type="checkbox"/> <b>Exit</b>	
Tool Used: _____	Date: _____
1. Child has positive social relationships. <input type="radio"/> 1. Not Yet <input type="radio"/> 2. <input type="radio"/> 3. Emerging <input type="radio"/> 4. <input type="radio"/> 5. Somewhat <input type="radio"/> 6. <input type="radio"/> 7. Completely Progress made: <input type="radio"/> Yes <input type="radio"/> No	
2. Child acquires and uses knowledge and skills. <input type="radio"/> 1. Not Yet <input type="radio"/> 2. <input type="radio"/> 3. Emerging <input type="radio"/> 4. <input type="radio"/> 5. Somewhat <input type="radio"/> 6. <input type="radio"/> 7. Completely Progress made: <input type="radio"/> Yes <input type="radio"/> No	
3. Child takes appropriate action to meet his/her needs. <input type="radio"/> 1. Not Yet <input type="radio"/> 2. <input type="radio"/> 3. Emerging <input type="radio"/> 4. <input type="radio"/> 5. Somewhat <input type="radio"/> 6. <input type="radio"/> 7. Completely Progress made: <input type="radio"/> Yes <input type="radio"/> No	

Team Members and Contributors			
Printed Name and Role	Signature	Agency	Phone/e-mail
		Parents	
		Service Coordinator	
		Lead Agency Rep.	
		LEA Representative	

Parent Consent (Please check all that apply)	
<input type="checkbox"/> I/We, as parent(s)/guardian(s), have had <i>Early On</i> and/or Special Education explained to me/us including my/our rights and the possibility of participation in an evaluation survey.	
<input type="checkbox"/> I/We have helped to develop this plan. <input type="checkbox"/> I/We understand and agree with its content. <input type="checkbox"/> I/We agree to each of the services I/we have initialed.	
<input type="checkbox"/> I/We have received a copy of the <input type="checkbox"/> <i>Welcome to Early On® Guidebook</i> <input type="checkbox"/> <i>Family Rights Guidebook</i> <input type="checkbox"/> <i>The Individualized Family Service Plan Guidebook</i> <input type="checkbox"/> <i>Transition Guidebook</i> <input type="checkbox"/> <i>Procedural Safeguards for Special Education</i>	
OR	
<input type="checkbox"/> I/We do not agree with this IFSP or IEP.	
<input type="checkbox"/> I/We decline <i>Early On</i> services.	

Parent(s) Signature: _____	Date: _____
Service Coordinator Signature: _____	Date: _____

## Transition Plan

Child's Legal Name: _____		Child's Current Age: _____		
The Transition Planning Conference must take place at least 90 days, but not prior to, nine months before the child's third birthday.				
Transition Conference Date: _____		Expected Transition Date: _____		
IEP Date (if appropriate) _____				
<b>Reason for Transition</b>				
<input type="checkbox"/> Child reached 3 <sup>rd</sup> birthday <input type="checkbox"/> Child no longer meets definition of eligibility for <i>Early On</i> <input type="checkbox"/> Parent no longer wants services <input type="checkbox"/> Family has moved <input type="checkbox"/> Unable to contact family <input type="checkbox"/> Other: _____				
<b>Child's Present Level of Development</b>				
Transition Needs: (check all that need to be addressed)		Updated Evaluations: (include results, instrument(s) used, date, and evaluator(s))		
<input type="checkbox"/> Health <input type="checkbox"/> Vision/Hearing <input type="checkbox"/> Gross Motor <input type="checkbox"/> Fine Motor <input type="checkbox"/> Communication <input type="checkbox"/> Thinking Skills <input type="checkbox"/> Social/Emotional <input type="checkbox"/> Adaptive				
Present Eligibility for Special Education: (check one) <input type="checkbox"/> Eligible <input type="checkbox"/> Potentially Eligible <input type="checkbox"/> Not Eligible				
<b>Steps &amp; Services to Support the Transition of the Child</b>				
<input type="checkbox"/> Discussion with parents regarding future placements of their child. <input type="checkbox"/> Procedures to prepare the child for changes in service delivery, including steps to help the child adjust to a new setting. <input type="checkbox"/> Prepare a visit to a potential program. <input type="checkbox"/> Explore other community resources. <input type="checkbox"/> Other				
Strategies that will be used to address the above steps: (the first 2 <u>must</u> be addressed)				
_____ _____ _____				
<b>Services that will end at my <i>Early On</i> Transition date:</b>				
Service	How Long/How Often	Location	End Date	Parent Initial
<b>Services that will continue beyond my <i>Early On</i> Transition date:</b>				
Service	How Long/How Often	Location	End Date	Parent Initial
<b>Disposition of <i>Early On</i>® Records</b>				
The following ✓ indicates the disposition of the child's <i>Early On</i> Record: <input type="checkbox"/> A copy will be forwarded to the receiving program/service provider. Name: _____ <input type="checkbox"/> The record will be placed in your child's Special Education File, maintained at _____ <input type="checkbox"/> The record will be maintained for a minimum of 7 years as required by law.				
Please use the signature page to document persons present during the Transition Conference, the progress made in the Child Outcomes and to document Parental Consent to the Transition Plan				

## Special Educational Accommodations, Modifications and Considerations

(To be completed for IEP's only)

Child's Legal Name: \_\_\_\_\_ Date: \_\_\_\_\_

The IEP/IFSP Team has considered supplementary aids and services, program modifications, and supports for school personnel required for the child to attain the annual goals. The Team considered accessibility of physical facilities, specialized transportation, assistive technology devices, & assistive technology services.

Service	Frequency/Duration/Condition	Initial Date	Duration Date	Location

This IFSP/IEP Team considered the need for a teacher endorsed in a particular category.

How will the developmental needs of this child be addressed during the summer months?

### IEP/IFSP Team Recommendation

This child is **Not eligible** for special education programs/services.

Outlines programs/services to be provided with the following **person assuring implementation** \_\_\_\_\_

All programs/services/modifications will begin on \_\_\_\_\_ end on \_\_\_\_\_ and continue for: *(choose one)*

One regular school year

An adapted school year

Other: *(Specify)* \_\_\_\_\_ Rationale: \_\_\_\_\_

One or more IEP/IFSP Team Members disagree with this recommendation. *(Complete & attach a dissenting report)*

### IEP/IFSP Commitment Signatures

#### Resident District

The resident district assures that the least restrictive/natural environment has been fully considered: *(Choose all that apply)*

**Agrees** with the recommendation of the IEP/IFSP Team and: *(check all that apply for eligible children)*

○ **Assigns** this child to the following program/school & operating district: \_\_\_\_\_

○ **Authorizes** the non-resident district to assign an appropriate school/program and conduct post-initial IEP/IFSP Team meetings.

**Does not agree** with the recommendation of the IEP/IFSP Team

Resident District Superintendent/Designee: \_\_\_\_\_

Date: \_\_\_\_\_

#### Operating District

The non-operating district assures that the least restrictive/natural environment has been fully considered and: *(choose all that apply)*

**Agrees** with the recommendation of the IEP/IFSP Team and: *check all that apply for eligible children)*

○ **Assigns** this child to the following program/school \_\_\_\_\_

○ **Agrees** to conduct post-initial IEP/IFSP meetings.

**Does not agree** with the recommendation of the IEP/IFSP Team

Operating District Superintendent/Designee: \_\_\_\_\_

Date: \_\_\_\_\_

#### Parent/Guardian

I, as parent/guardian,  have had *Early On*<sup>®</sup> and Special Education explained to me,  have helped to develop this plan & understand its contents,  have received a copy of & understand my Procedural Safeguards *(check all that apply)*

I **Authorize** the sharing of information with agencies that will implement this plan.

I **Agree** to the content and implementation of this plan, and its referrals

I **Do not agree** with the IEP/IFSP

Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Parent/Guardian did not attend. Report copy was sent by: \_\_\_\_\_

Date: \_\_\_\_\_