

Michigan Individualized Family Service Plan

Referral Source to <i>Early On</i> ®:		Date of Referral:	
Child's Legal Name:		Date of Initial IFSP Mtg.	
Current Address:			
Date of Birth:	City of Birth:	SS#:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Ethnic Heritage: <input type="checkbox"/> Asian American <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander			
Present concerns and/or diagnosis:			
School District of Residence:		County:	
Immunizations:		Date of 1st DPT:	
<input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Family Member <input type="checkbox"/> Foster Parent <input type="checkbox"/> Surrogate Parent			
Name:			
Address:		City:	State: Zip:
Telephone: Day:		Evenings:	Native Language:
Interpreter Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No		Interpreter Provided: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Family Member <input type="checkbox"/> Foster Parent <input type="checkbox"/> Surrogate Parent			
Name:			
Address:		City:	State: Zip:
Telephone: Day:		Evenings:	Native Language:
Interpreter Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No		Interpreter Provided: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Other Family Members (include Name & Relationship)		Health Care Providers	
Primary Health Care Provider:		Telephone:	
Address:			
Service Coordinator:		Telephone:	
Type of IFSP			
<input type="checkbox"/> Interim IFSP/Date:		<input type="checkbox"/> Initial IFSP Signature/Date:	
<input type="checkbox"/> 6 Month Review/Date:		<input type="checkbox"/> Annual Review/Date:	
<input type="checkbox"/> Transition/Date:		<input type="checkbox"/> Other Review/Date:	
Special circumstances that delayed IFSP > 45 days after referral:			

Child's Name:

BD:

Date

Family Information

If the family has given permission to an interview on the "Consent to Evaluate" Form

	Family Resources/ Strengths	Family Concerns	Family Priorities
<u>MEDICAL/HEALTH</u> (Doctor, Insurance, Immunizations, Nutrition, Dental, Substance use, Current medications, Hearing, Vision)			
<u>EDUCATION/DEVELOPMENTAL</u> (Rehabilitation Services, Skill Development, School, GED, Technical Training, College, etc.)			
<u>MATERIAL NEEDS</u> (Transportation, Housing, Utilities, Food, Clothing, etc.)			
<u>EMPLOYMENT/FINANCIAL</u> (Work, Income, Budgeting, CSHCS, SSI, etc.)			
<u>LEGAL</u> (Custody-Court Involvement, Legal Aide, Child-Support, Evictions, Civil Disputes, etc.)			
<u>SAFETY</u> (Physical Environment, Domestic Violence, Child Abuse/Neglect, Medical Issues, Mental Health Issues, etc.)			
<u>SOCIAL/LEISURE/SPIRITUAL</u> (Religious Organizations, Cultural, Recreational, Friends, etc.)			
<u>PSYCHOLOGICAL/EMOTIONAL</u> (Respite, Self-Image, Family Relationships, Mental Health, Stress, loss, etc.)			

Prioritize family concerns/needs by placing a number next to each item in order of priority in the Family Priority column.

Child's Name: _____ BD: _____ Date: _____

Chronological Age: _____ If Premature, Adjusted Age: _____

Child's Current Developmental Status

Informed clinical opinion to determine eligibility must be based on the integration of all 4 of the following sources of information. Check all that have been used:

- Developmental History**
 Health Status
 Observation of Parent & Child
 Developmental Evaluation
 See Attached Report incorporating the above 4 sources Date of Multidisciplinary Evaluation _____

Eligibility: _____ Established Condition: _____ Developmental Delay: _____

Special Education: Rule # _____

Area	Present Level of Development		Method/Tool/Date Person Completing: Name/Title	Family Priority
	Parent Input	Result of Dev. Evaluation		
Health <input type="checkbox"/> See Attached Report				
Hearing <input type="checkbox"/> See Attached Report				
Vision <input type="checkbox"/> See Attached Report				
Fine Motor <input type="checkbox"/> See Attached Report				
Gross Motor <input type="checkbox"/> See Attached Report				
Cognitive/ Thinking <input type="checkbox"/> See Attached Report				
Communication <input type="checkbox"/> See Attached Report				
Social/ Emotional <input type="checkbox"/> See Attached Report				
Adaptive <input type="checkbox"/> See Attached Report				

Where will/did this evaluation take place?

Who should be/was present?

Child's Name:	BD:	Date:					
Part C Outcome #							
GOAL/OUTCOME STATEMENT – What the parent would like to see happen for this child/family, including: A – Audience (Person targeted); B – Behavior (Procedures to be used); C – Criteria ; D – Duration (Time line) Priority: <i>(Please circle)</i> 1 2 3 4 5 6 7 8							
Concern of Parent:							
Present Status – What is happening now?							
Steps/Objectives – To reach this outcome	Expected Time Frame						
Strategies/Methods - for working on this outcome during this child & family's daily routines and activities.	People to be involved						
If this outcome cannot be met in the natural environment with supplementary supports explain why it cannot not be met there and the timeline for it's inclusion into the child's natural environment. Complete page 8 for each outcome that is not provided in a child's natural environment.							
Service Code	Parents Initials	Frequency (how often?) Intensity (How long?)	Individual Or Group	Starting Date	Ending Date	Location Code	Funder
Date for reviewing the progress made on this outcome (must be within 6 months of the date written):							

Other Services

To the extent appropriate, the IFSP must document services that are not required or covered under Part C. Listing the non-required services does not mean that those services must be provided, however, their identification can be helpful to both the family and the service coordinator to assist in securing those services, including those through public or private sources. These services must correspond to family identified outcomes.

Service	Outcome #	Start Date Mo/Day/Yr	Duration (months)	Provider Information	Funding

IFSP Development Team and Contributors

Printed Name & Role	Signature	Agency (if applicable)	Phone

Parent Consent:

- I/We, as parent(s)/guardian(s), have had *Early On* explained to me/us including my/our rights and possible participation in an evaluation survey.
 - I/We have helped to develop this plan. I/We understand and agree with its content. I/We agree to each of the services I/We have initialed
 - I/We have received a copy of *The Family Guidebook, Family Rights Pamphlet*
- OR**
- I do not agree with this IFSP & I request mediation and/or an impartial due process hearing¹

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

¹If a parent or public agency disagrees with this IFSP, either party has the right to request a due process hearing by following the procedures outlined in the Procedural Safeguards.

Child's Name:

BD:

Date:

Review of Outcomes

Review of Outcomes must be conducted at least every six months OR more frequently if the family requests a review to determine the degree of progress toward achieving outcomes and whether modifications or revision of the outcomes or services is necessary.

The Team will use the following scale to evaluate progress: 1 – Situation changed, outcome not needed; 2 – Situation unchanged, still need outcome; 3 – Outcome partially attained; 4 – Outcome accomplished.

Outcome # _____

Team Evaluation (Use codes from above):

Progress Summary: (What has changed since the outcome was last written or reviewed?)

Modifications/Revisions: (What changes need to be made with this Outcome?)

I participated in the review of this outcome (Parent check and initial)

Outcome # _____

Team Evaluation (Use codes from above):

Progress Summary: (What has changed since the outcome was last written or reviewed?)

Modifications/Revisions: (What changes need to be made with this Outcome?)

I participated in the review of this outcome

Parent Signature:

Date:

Service Coordinator/Provider

Date:

Child's Name:

BD:

Date:

Annual Assessment of Child's Progress

Area	Parent Input	Professional Input/Method/Checklist
Health Status		
Hearing		
Vision		
Gross Motor		
Fine Motor		
Cognitive/ Thinking		
Communication		
Social/ Emotional		
Adaptive		

Family's Concerns

Priorities:

This page must be completed within one year of the initial IFSP & every year thereafter.