Infant & Toddler Connection of Virginia

Individualized Family Service Plan (IFSP)

Council Name Here

Program Name Here (Optional)

I. Child and Family Information

Child's Name: _____ **Date of Birth:** _____

Gender: _____ **Child's County or City of Residence:** _____

IFSP Date: _____ ☐ **Initial** ☐ **Annual #** _____ **Date 6 mo. Review Completed:** _____

Date(s) Other Review(s) Completed: _____ _____ _____

Family's Primary Language and/or Mode of Communication: _____ **Child's** *(if different)*: _____

Parent's and/or Other Family Member's Name, Address, Phone And Other Contacts:

Service Coordinator's Name, Agency, Address, Phone and Fax Numbers:

Early Intervention services are provided to eligible children and their families in compliance with Part C of the federal *Individuals with Disabilities Education Act.*

IIa. Child and Family Typical Routines and Community Activities

(What we want the people helping us to know about our everyday routines and activities: places we go or would like to go, people we are with or would like to be with, activities we do or would like to do, and activities our child enjoys.)

IIb. Family Identified Resources, Priorities, & Concerns

(What we want the people helping us to know about the concerns and priorities we have about our child's development, and the resources, supports, and services we have or need to help us.)

Voluntary on behalf of the family!
Your child can still receive services if you do not complete this section.
_____ *Parent initial if choosing not to provide this information.*
_____ *Parent initial if choosing not to include this information in the IFSP.*

IIIa. Team Evaluation

Area of Development	Developmental Evaluation Results *(May include age levels or ranges)*	Methods/Instruments Used	Evaluation Date Chronological Age Adjusted Age	Evaluator(s) Initials
Cognitive *(Thinking and learning)*			**Date:** **CA:** **AA:**	
Expressive Communication *(Making sounds, gestures, and talking)*			**Date:** **CA:** **AA:**	
Receptive Communication *(Understanding sounds, words, and gestures)*			**Date:** **CA:** **AA:**	
Gross motor *(Moving and using large muscles)*			**Date:** **CA:** **AA:**	
Fine motor *(Using hands and fingers)*			**Date:** **CA:** **AA:**	
Social/Emotional *(Interacting with others)*			**Date:** **CA:** **AA:**	
Adaptive *(Feeding/eating, dressing, and sleeping)*			**Date:** **CA:** **AA:**	

Vision :

Hearing:

Eligibility for Part C Services:

☐ Child is eligible for Part C Services because he/she has *(check one or more below and list name or describe each)*:

- ☐ a 25% delay in development in one or more areas (*list*): _____
- ☐ atypical development and/or behavior (*describe*): _____
- ☐ a diagnosed condition that is likely to result in delay in development (*name*): _____

☐ Child is not eligible for Part C services because he/she does not meet the above criteria. This form serves as an evaluation record only.

IIIb. Team Evaluation – Narrative

- Diagnosis and/or reason for referral
- Health and physical development *(pertinent history, current health status, clinical signs and symptoms)*
- Statement of child's level of development in <u>all</u> developmental areas
- Summary of functional strengths and limitations

Recommendation about the benefit of intervention:

The following people participated in the evaluation (*Printed name, credentials, role/organization, signature, date*)**:**

**Recommended Services are listed on pages 5 and 6. **

IIIb. Team Evaluation - Narrative

- Diagnosis and/or reason for referral
- Health and physical development *(pertinent history, current health status, clinical signs and symptoms)*
- Statement of child's present level of development in <u>all</u> developmental areas
- Summary of functional strengths and limitations

Continued on next page

IIIb. Team Evaluation – Narrative *(continued)*

Recommendation about the benefit of intervention: _____

The following people participated in the evaluation (*Printed name, credentials, role/organization, signature, date*)**:**

Recommended Services are listed on pages 5 and 6.

Child's Name: _____

Infant & Toddler Connection of Virginia

IFSP Date: _____ **DOB:** _____ **Page 5**

IV. Outcomes of Early Intervention

Review Date: _____

Outcome (Long-Term Goal) **#** **1** **:** **Start Date:** _____ **End Date:** _____

In order to help the child and family receive the supports and services they need, the service coordinator/Targeted Mental Retardation Case Manager will assure:

- that the IFSP addresses the family's identified concerns, priorities and resources;
- the appropriateness and adequacy of services;
- family satisfaction with services; and
- that consumer rights are protected.

Short-Term Goals	**Target Date**	**Date Met**
Assist family with the development and ongoing review and revision of the IFSP.		
Provide supports identified by the family to include resources for:		

Service Coordination/Case Management Activities *(Interventions)*:

- Maintain ongoing contact with family for service monitoring (*communicate at least monthly; face to face meetings at least every 90 days*).
- Phone calls/personal contacts with family and with individuals/agencies that provide support, assistance, services.
- Link family with appropriate community resources.
- Review services at least quarterly.
- Assists with problem solving.

Service Coordinator/MR Case Manager *(printed name, credentials, organization, signature, date)*

Comments on progress *(Degree to which outcome is met and revisions as needed)*:

IV. Outcomes of Early Intervention

Review Date: _____

Outcome (Long-Term Functional Goal) # _____ **Target Date:** _____ **Date met, changed or ended:** _____

Learning opportunities and activities that build on child's and family's interests and abilities:

Short-Term Goals	**Target Date**	**Date Met**

Interventions *(Treatment procedures and/or modalities)* **NOTE: This section should be completed only after determination of all outcomes.**

Comments on progress *(Degree to which outcome is met and revisions as needed)*:

Outcome plan reviewed on _____ by _____

Child's Name: _____

IFSP Date: _____ **DOB:** _____ **Page** 6

V. Services Needed to Achieve Early Intervention Outcomes

The IFSP Team agrees that social services are required (counseling services to assist the family in understanding their child's special needs). Yes___ No ___

SERVICE	AGENCY NAME, ADDRESS, PHONE	FREQUENCY; INTENSITY; METHODS *(# x/wk; # min/visit; group or individual)*	NATURAL ENVIRONMENT/ LOCATION* *(Must be a natural setting unless justified below)*	PAYMENT *(Family, Insurance, Medicaid, Part C, other...)*	START DATE	PROJECTED END DATE	ACTUAL END DATE
Service Coordination							

***Justification of why early intervention outcomes can't be achieved satisfactorily in a natural setting:**

Discharge Planning: Early Intervention services will be discontinued when the IFSP team determines that services are no longer needed to achieve the outcomes. *(For details see page 7)*.

VII. Other Services *(Services needed, but not entitled under Part C - including medical services such as well baby checks, follow-up with specialists for medical purposes, etc.)*

SERVICE	PROVIDER	LOCATION	FUNDING SOURCES OR STEPS TO BE TAKEN TO SECURE SERVICES

Child's Name: _____

IFSP Date: _____ **DOB:** _____ **Page 7**

VI. Transition Planning

TRANSITION PLANS AND ACTIVITIES	PERSON RESPONSIBLE	DATE STARTED	DATE COMPLETED
☐ 1. Discuss what "transition" from early intervention means and what we can do to plan for this transition. I do not want this information to be transmitted. _____ Parent initials/ Date			
☐ 2. Discuss eligibility and age guidelines for early intervention so we understand when our child may no longer be eligible for early intervention services.			
☐ 3. Our child's name, address, phone number and birth date will be sent to the school division no later than unless we disagree.			
☐ 4. Help us explore preschool special education services as well as other community program options for our child, including: eligibility for the program, the latest date a referral may be made to the program to ensure we don't have a gap in services, and who we can talk to for more information. (Latest date:)			
☐ 5. Help our child begin to learn new skills needed to better get along in the new place (see Outcome(s) #).			
☐ 6. With our permission, provide specific information to the future service provider or program (*e.g., assessment reports, IFSP, etc*.)			
☐ 7. Schedule a meeting with our family, service coordinator, and someone from the new program to plan how we are going to make the transition.			
☐ 8. Help our child and family prepare for changes in services so that we can move smoothly from one program to another (*e.g., meet a new teacher, visit a classroom, talk by phone to a program in the area where we are moving).*			

Additional Steps			

VII. IFSP AGREEMENT

Payment

- Service coordination, evaluations and assessments, and the development of this plan are provided to us free of charge and will not be billed to any private insurance.
- My health insurance will be billed for other medically necessary services, as appropriate, if I give consent.
- I am responsible for paying our co-payments, deductibles, etc. and for non-covered services. If I cannot afford the cost of services, fees may be reduced according to the fee system which assesses our ability to pay.
- Public funds under *Part C of the Individuals with Disabilities Education Act* may be used to support Early Intervention services only after all other funding sources have been exhausted.

Parental Consent for Provision of Early Intervention Services:

I have received a copy of family rights under Part C of IDEA (*Notice of Child and Family Rights in the Infant & Toddler Connection of Virginia Part C Early Intervention System*) and a copy of "Facts about Family Fees" (for annual IFSP) along with this IFSP. These rights and information about family fees have been explained to me and I understand them. I participated in the development of this IFSP and I give informed consent for Infant & Toddler Connection of Virginia system and service providers to carry out the activity(ies) listed on this IFSP.

Consent means: that I have been fully informed of all information about the activity(ies) for which consent is sought, in my native language (unless clearly not feasible to do so) or other mode of communication; that I understand and agree in writing to the carrying out of the activity(ies) for which consent is sought; the consent describes that activity(ies); and the granting of my consent is voluntary and may be revoked in writing at any time.

I understand that I may decline a service or services without jeopardizing any other early intervention service(s) my child or family receive through the Infant & Toddler Connection of Virginia system.

I understand that my IFSP will be shared among the Infant & Toddler Connection of Virginia system and service providers implementing this IFS

Signature(s) of *(check one)*: ☐ Parent(s) ☐ Legal Guardian ☐ Surrogate Parent Date

Other IFSP Participants (*Printed name, credentials, role/organization, signature, date*)**:**

VIII. IFSP Review Record

IFSP Review

Purpose of Review: ☐ 6 month Review ☐ Upon Request by: Review Date:

Summary (*Include rationale for any changes resulting from this review*) **:**

Change(s):

Date Change Effective:

The following individuals participated electronically or in writing (*specify which*):

The following related documents are attached:

Copies to:

Parental Consent

I have received a copy of family rights under Part C of IDEA (*Notice of Child and Family Rights in the Infant & Toddler Connection of Virginia Part C Early Intervention System*) along with this IFSP Review Record. These rights have been explained to me and I understand them. I participated in the development of this IFSP Review and I give informed consent for Infant & Toddler Connection of Virginia system and service providers to carry out any changes listed on this IFSP Review Record.

Consent means: that I have been fully informed of all information about the activity(ies) for which consent is sought, in my native language (unless clearly not feasible to do so) or other mode of communication; that I understand and agree in writing to the carrying out of the activity(ies) for which consent is sought; the consent describes that activity(ies); and the granting of my consent is voluntary and may be revoked in writing at any time.

I understand that I may decline a service or services without jeopardizing any other early intervention service(s) my child or family receive through the Infant & Toddler Connection of Virginia system.

I understand that my IFSP will be shared among the Infant & Toddler Connection of Virginia system and service providers implementing this IFSP.

Signature of *(check one)*: ☐ Parent(s) ☐ Legal Guardian ☐ Surrogate Parent Date

Other IFSP Participants (*Printed name, credentials, role/organization, signature, date*):

The following individuals participated electronically or in writing (specify which):

For Insurance purposes only:

I certify and approve that the services, as described above, are medically necessary for this child.

, M.D.

Physician's signature date