



Infant & Toddler Connection of Virginia

LICC/Provider Label (w/ Phone Number)

TO: Family
 Address
 City, State & Zip

RE: Child's Name
 ID Number

Confirmation of Individualized Family Service Plan (IFSP) Schedule ITCV-PS-5(R)9/02

Date: _____

Dear: _____

I would like to confirm the IFSP team meeting/review schedule previously discussed for your child. The IFSP team meeting/review has been scheduled at the convenience of your family and can be rescheduled if needed. The IFSP meeting/review has been scheduled for:

Date	Time	Place

The type of IFSP meeting/review that this will be is:

initial annual 6-month review other _____

As we have talked about, the purpose of the IFSP team meeting/review is to discuss information related to your child's development and to develop a family plan which includes outcomes, strategies, services and supports determined appropriate for your child and family by the team. An initial IFSP must be completed within 45 calendar days from the time your child was referred to Part C unless you extend this timeline to meet your family's needs. Thereafter, IFSP's must be reviewed every six months and an annual meeting/review must be held to evaluate the IFSP and revise as necessary.

Individuals who will provide information to develop the IFSP are listed below. They may not actually be present at the meeting/review, but they will provide written or oral information. All of this information will be shared with you at the meeting/review. You may invite anyone you wish to participate in the meeting/review.

Names (Individual or Providing Agency)

Discipline

Please call me/us if you have any questions about the above information or schedule.

Sincerely,

Name(s)/Title(s)

cc: IFSP Team Members (listed above)

Note: *Parents are to receive a copy of this form.*

DMH 888E 1048 R12/02

<input type="checkbox"/> Mailed	<input type="checkbox"/> Hand Delivered
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