

Infant & Toddler Connection of Virginia
Individualized Family Service Plan (IFSP)
Local System Name Here



I. Child and Family Information

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

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

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

Dates Quarterly Medicaid Targeted Case Management (TCM) reviews due: _____

Date(s) IFSP/TCM Reviews Completed: _____

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

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

Medicaid Number (optional): _____

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

Service Coordinator's / Case Manager's Name, Agency, Address, Phone, Email and Fax Numbers :

This IFSP also serves as the Person Centered Individual Support Plan for Medicaid Targeted Case Management from _____ (start date) to _____ (end date).

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

Child's Name: _____
IFSP Date: _____ DOB: _____



Ila. Child and Family 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.)

Ilb. Family Identified Resources, Priorities, & Concerns

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

<p>Voluntary! Your child can still receive services if you do not complete section Ilb. _____ Parent initial if choosing not to provide this information. _____ Parent initial if choosing not to include this information in the IFSP.</p>
--

Child's Name: _____
IFSP Date: _____ DOB: _____



IIc. Social Assessment (Required for Medicaid Targeted Case Management) continued

Financial, insurance, transportation and other resources (including any income in child's name):

Strengths, personal preferences and desires:

Summary of prior services that have or have not been successful:

Empowerment/advocacy/volunteerism:

Communication barriers:

Child's Name: _____
IFSP Date: _____ DOB: _____



IV. Outcomes of Early Intervention

Your child will receive: Service Coordination Service Coordination/ TCM (Medicaid Targeted Case Management)

Outcome (Long-Term Goal) # 1 – Service Coordination (required)

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

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

Short-Term Goals

Assist your family with the development and ongoing review and revision of the IFSP.

Target Date

Date Met

ongoing

Provide support and assistance to your family in addressing issues or concerns that emerge over time.

ongoing

Provide supports identified by your family to include resources for:

Short-Term Goals	Target Date	Date Met
Assist your family with the development and ongoing review and revision of the IFSP.	ongoing	_____
Provide support and assistance to your family in addressing issues or concerns that emerge over time.	ongoing	_____
Provide supports identified by your family to include resources for:		
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Service Coordination Activities (Interventions):

- Maintain ongoing contact with you for service monitoring
- Phone calls/personal contacts with your family and with individuals/agencies that provide support, assistance, services.
- Review services at least quarterly.
- Link your family with appropriate community resources.
- Assist with problem solving.

Service Coordinator/Targeted Case Manager (Printed Name, Credentials, Role/organization)

Child's Name: _____

IFSP Date: _____ DOB: _____



IV. Outcomes of Early Intervention

Date Outcome Added: _____

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)

Child's Name: _____
 IFSP Date: _____ DOB: _____



V. Services Needed to Achieve Early Intervention Outcomes

ENTITLED SERVICE	FREQUENCY (# x/wk/ month/once)	INTENSITY (# min/visit)	GROUP (G) / INDIVIDUAL (I)	METHODS** (a,b,c,d)	NATURAL ENVIRONMENT/ LOCATION <i>(Must be a natural setting unless justified below)</i>	PAYMENT 1 Family Fee 2 Insurance 3 Medicaid, 4. State Funds 5. Local Funds 6. Part C	PROJECTED START DATE	PROJECTED END DATE	ACTUAL END DATE
1. Service Coordination	*	*		Service coordination					
2.									
3.									
4.									
5.									
6.									
7.									
8.									

* This is the minimum frequency and intensity of direct contact from your service coordinator. The frequency and intensity of service coordination actually provided will vary since service coordination is an active, ongoing process that changes based on your family's priorities and needs.

** Methods: a = Coaching, including hands-on as appropriate b = Consultation c = Assessment
 d = Provision of assistive technology device

Justification of why early intervention outcomes can't be achieved satisfactorily in a natural setting and a plan with timelines and supports necessary to return early intervention services to natural settings:

Reason for later projected start date - For each service that is planned to start more than 30 calendar days after the family signs the IFSP, indicate whether the reason is family scheduling preference, team planned a later start date to meet child and family needs, or other:

VI. 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	STEPS TO BE TAKEN TO ASSIST IN SECURING SERVICES

Child's Name: _____
 IFSP Date: _____ DOB: _____



VII. Transition Planning

The following information about transition is discussed beginning at the initial IFSP:

- Transition happens when your child leaves early intervention. The planning on this page will help you and your child move smoothly from early intervention to whatever comes next for your child.
- Options after early intervention (examples: community programs like neighborhood nursery schools, Head Start, early childhood special education through the public schools).
- Possible timing of transition
 - When your child reaches age level in all developmental areas and meets no other eligibility requirements for early intervention
 - When your child reaches his/her third birthday, which is the end of eligibility for early intervention
 - When and if your child becomes eligible for early childhood special education services through the public schools (between age 2 and 3), if you are interested in those services. Children may not be served in early intervention and early childhood special education through the public schools at the same time.

This information was discussed on _____ (date) by _____ (initials of service coordinator)

Important Dates for Transition Planning:

_____ - target date for referral to determine eligibility if you are interested in early childhood special education services through your local school system (referral must occur by April 1 of the year your child turns 2 by Sept. 30 if you want your child to begin school on the first day of the next school year).

_____ (date of child's 3rd birthday) – date on which your child is no longer eligible to receive early intervention

Notification to the Local School Division:

Our child's name, address, phone number and birth date will be sent to the _____ (school division) no later than _____ (date) unless we disagree. Sending this information helps the school division to know who in the community may be eligible for special education services. This is not a referral for such services and does not mean you are interested in such services.

I do not want my child's name, address, phone number and birth date sent to the local school division. _____ (parent initials/date)

I have changed my mind and agree to have this information sent to the local school division. _____ (parent initials/date)

Date Notification Sent: _____ (parent initials/date)

Transition Planning Requirements

The transition activities completed will depend on your transition plans and family preferences.

Transition Steps/Activities	Target Date	Date Completed	Initials Person Completing
Based on your transition plans and family preferences, your service coordinator will:			
1. Help your family explore community program options, which may include early childhood special education services, for your child <ul style="list-style-type: none"> a. Provide information, including program contact information, about community options following early intervention, as desired by your family. Information provided on the following programs: b. Arrange for visits to programs, as desired by your family. Programs visited: c. Provide names of other families (with their permission) who have transitioned to programs the family is considering, as desired by your family. d. Other steps/activities: 			

<p style="text-align: center;">Transition Steps/Activities</p> <p style="text-align: center;">Based on your transition plans and family preferences, your service coordinator will:</p>	Target Date	Date Completed	Initials Person Completing
<p>2. With your permission, make a referral to the local school division or other desired program(s)</p> <p>a. Parent consent obtained on release of information form on _____ (date)</p> <p>b. With parent consent on release of information form, refer your child and send child- specific information to the future service provider or program (e.g., assessment reports, IFSP, etc.) List information sent:</p> <p>c. Referral sent to _____ (program) on _____ (date)</p> <p>d. Other steps/activities:</p>			
<p>3. If your family is considering transition to early childhood special education services, hold the 90-day transition conference between you, your service coordinator, and someone from the new program to plan how to make the transition.</p> <p>a. <i>Parental Prior Notice</i> form provided on _____ (date)</p> <p>b. Parent <input type="checkbox"/> approves/ <input type="checkbox"/> does not approve conference.</p> <p>c. Service Coordinator ensures scheduling of conference and participation by required parties by (check one):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Transition conference held on _____ (date) <input type="checkbox"/> The following participated: <input type="checkbox"/> (Parent - required), <input type="checkbox"/> (early intervention- required), <input type="checkbox"/> (school division - required), <input type="checkbox"/> (other) <input type="checkbox"/> (other) <p>d. Results of transition conference (e.g., planning for any further evaluation, IEP meeting including determination of placement, etc.):</p>			
<p>4. Once it has been determined where your child will transition, help your child and family prepare, as desired by your family, for changes in supports and services so you can move smoothly from one program to another</p> <p>a. Your child will transition to _____ on _____ (projected date)</p> <p>b. Help your child and family get ready for the new program/setting by:</p>			
<p>5. Discharge your child from the local Part C system on or before his/her 3rd birthday</p> <p>a. <i>Parental Prior Notice</i> form is signed <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>b. If child is on inactive status: <i>Parental Prior Notice</i> form sent on _____ (date) <i>Parental Prior Notice</i> form is signed <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>c. Date of discharge/closure _____</p>			

Child's Name: _____
IFSP Date: _____ DOB: _____



VIII. IFSP AGREEMENT

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 Cost Share" (for annual IFSP) along with this IFSP. These rights and the information about family cost share have been explained to me and I understand them. I participated in the development of this IFSP and I give informed consent for the Infant & Toddler Connection of Virginia system and service providers to carry out the activity(ies) listed on this IFSP.

Consent means 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 within the local Infant & Toddler Connection of Virginia system, including with providers involved in assessment and/or in the development and/or implementation of this IFSP.

Signature(s) 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*):

Translator/Interpreter (*if used*):

The following related documents are attached:

Copies to:

Physician Certification (Required in order to bill insurance): I certify and approve that _____ services, as described in the IFSP, are medically necessary for this child.

Signature

Credentials

Date

Child's Name: _____

IFSP Date: _____ DOB: _____



IX. IFSP Review Record

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

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

Change(s): _____ Projected start date for change: _____

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 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 within the local Infant & Toddler Connection of Virginia system, including with providers involved in assessment and/or in the development and/or implementation of this IFSP.

Signature(s) 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):

Physician Certification (Required in order to bill insurance): I certify and approve that

services, as described in the IFSP, are medically necessary for this child.

Signature

Credentials

Date

Child's Name: _____
IFSP Date: _____ DOB: _____



IX. IFSP Review Record

Purpose of Review: Quarterly TCM/IFSP Review

Review Date: _____

Summary (Include rationale for any changes resulting from this review):
General Status (including health and safety):

Significant events:

Progress or lack of progress:

Satisfaction with services:

Change(s):

Projected start date for change:

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 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 within the local Infant & Toddler Connection of Virginia system, including with providers involved in assessment and/or in the development and/or implementation of this IFSP.

Signature(s) 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):

Physician Certification (Required in order to bill insurance): I certify and approve that

services, as described in the IFSP, are medically necessary for this child.

Signature

Credentials

Date

Child's Name: _____

**Infant & Toddler
Connection of Virginia
Addendum**



IFSP Date: _____ DOB: _____

(Refer to corresponding number on page 6 of the IFSP for service details)

#	Service	SERVICE PROVIDER <small>(Name, agency, address, phone number)</small>	Current?
1	Service Coordination		<input type="checkbox"/> N
			<input type="checkbox"/> N
			<input type="checkbox"/> N
2			<input type="checkbox"/> N
			<input type="checkbox"/> N
			<input type="checkbox"/> N
3			<input type="checkbox"/> N
			<input type="checkbox"/> N
			<input type="checkbox"/> N
4			<input type="checkbox"/> N
			<input type="checkbox"/> N
			<input type="checkbox"/> N
5			<input type="checkbox"/> N
			<input type="checkbox"/> N
			<input type="checkbox"/> N
6			<input type="checkbox"/> N
			<input type="checkbox"/> N
			<input type="checkbox"/> N
7			<input type="checkbox"/> N
			<input type="checkbox"/> N
			<input type="checkbox"/> N
8			<input type="checkbox"/> N
			<input type="checkbox"/> N
			<input type="checkbox"/> N

I was given the opportunity to choose from among provider agencies who work in my local system area and who are in my payor network. I may request to change service providers at any time by contacting my service coordinator.

For Services # _____ Signature(s) of *(check one)*: Parent(s) Legal Guardian Surrogate Parent _____ Date

For Services # _____ Signature(s) of *(check one)*: Parent(s) Legal Guardian Surrogate Parent _____ Date

For Services # _____ Signature(s) of *(check one)*: Parent(s) Legal Guardian Surrogate Parent _____ Date