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.*

IIa. 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.)

IIb. 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.)

Voluntary!
Your child can still receive services if you do not complete section IIb.

_____ *Parent initial if choosing not to provide this information.*

_____ *Parent initial if choosing not to include this information in the IFSP.*

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

Home and daily living (including housing information/needs):
Leisure and recreation:
Education and vocation:
Relationships and social supports:
Physical/mental health, safety and behavior issues (including challenging behaviors, medical needs, medications, and nutritional needs):
Financial, insurance, transportation and other resources (including any income in child's name):
Legal issues and guardianship:
Empowerment/advocacy/volunteerism:
Strengths, personal preferences and desires:
Summary of prior services that have or have not been successful:
Communication barriers:

III. Team Assessment Narrative

Include the referral source and reason for referral, any medical diagnoses (especially those related to the reason for referral), pertinent health and physical development information (including pertinent medical history, clinical signs and symptoms, current health status), a statement of child's present levels of development in all areas of development, vision and hearing screening results, and a summary of functional strengths and limitations.

The following people participated in the assessment for service planning (*Printed name, credentials, role/organization, signature, date*):

Information from the following assessments completed outside the Infant & Toddler Connection of Virginia system was used to complete the assessment for service planning (*Printed name, credentials, organization*):

Eligibility for Medicaid Targeted Case Management

☐ Your child is eligible for Targeted Case Management because he/she has (check one or more):
- ☐ a delay in cognitive and adaptive development (for TCM adaptive skill areas include communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure)
- ☐ a qualifying diagnosed condition

☐ Your child is not eligible for Targeted Case Management

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	**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 *(Name, Credentials, Role/organization)*

_____

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)

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 (Must be a natural setting unless justified below)	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:

Transition Planning Requirements

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

Transition Steps/Activities Based on your transition plans and family preferences, your service coordinator will:	**Target Date**	**Date Completed**	**Initials Person Completing**
1. Help your family explore community program options, which may include early childhood special education services, for your child 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: _____	_____	_____	___
2. With your permission, make a referral to the local school division or other desired program(s) a. Parent consent obtained on release of information form on _____ (date) 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: _____ c. Referral sent to _____ (program) on _____ (date) d. Other steps/activities: _____	_____	_____	___

Child's Name: _____

IFSP Date: _____ **DOB:** _____

Transition Steps/Activities Based on your transition plans and family preferences, your service coordinator will:	**Target Date**	**Date Completed**	**Initials Person Completing**
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. a. *Parental Prior Notice* form provided on _____ (date) b. Parent ☐ approves/ ☐ does not approve conference. c. Service Coordinator ensures scheduling of conference and participation by required parties by (check one): ○ Transition conference held on _____ (date) ○ The following participated: ☐ (Parent - required), ☐ (early intervention- required), ☐ (school division - required), ☐ (other) ☐ (other) d. Results of transition conference (e.g., planning for any further evaluation, IEP meeting including determination of placement, etc.): _____	_____	_____	___
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 a. Your child will transition to _____ on _____ (projected date) b. Help your child and family get ready for the new program/setting by: _____	_____	_____	___
5. Discharge your child from the local Part C system on or before his/her 3rd birthday a. *Parental Prior Notice* form is signed ☐Yes ☐No b. If child is on inactive status: *Parental Prior Notice* form sent on _____ (date) *Parental Prior Notice* form is signed ☐Yes ☐No c. Date of discharge/closure _____	_____	_____	___

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 among the Infant & Toddler Connection of Virginia system and service providers implementing 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:** _____

Infant & Toddler Connection of Virginia

Addendum

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

#	Service	SERVICE PROVIDER *(Name, agency, address, phone number)*	Current?
1	Service Coordination		☐ N
			☐ N
			☐ N
2			☐ N
			☐ N
			☐ N
3			☐ N
			☐ N
			☐ N
4			☐ N
			☐ N
			☐ N
5			☐ N
			☐ N
			☐ N
6			☐ N
			☐ N
			☐ N
7			☐ N
			☐ N
			☐ N
8			☐ N
			☐ N
			☐ 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