☐ Individualized Family Service Plan-IFSP
☐ Individualized Educational Plan – IEP

(Please check the one(s) that apply.)

Date: ____________

Child's Legal Name: ______________________ **Date of Birth:** ____________

Address of Child: ______________ **City:** ____________ **Zip Code:** ____________

☐ Male ☐ Female (check one) City of Birth: ______________ Birth Order (if multiple) ______
Child's ID#: ____________

Ethnic Heritage:
☐ Hispanic or Latino
☐ American Indian or Alaska Native
☐ Black or African American
☐ White including Middle Eastern
☐ Asian American
☐ Native Hawaiian or other Pacific Islander

Resident ISD/RESA/RESD: **Resident Local District:**

Parent/Guardian Name	Relationship to Child	Native Language/ Interpreter Needed?	Phone-Day-Other/E-mail
		☐ Yes Interpreter needed	
		☐ Yes Interpreter needed	
		☐ Yes Interpreter needed	

Address if different from child:

Status: ☐ *Early On*® Referral ☐ *Early On* Transfer ☐ Special Ed Referral ☐ Special Ed Transfer
(check all that apply)
Date of Referral: ______________ Date of Transfer: ______________
Referral Source: ______________ Transferred in from: ______________

Eligibility: ☐ *Early On* ☐ Special Education ☐ Both ☐ Not Eligible
(Complete and sign the eligibility determination sheet.)

Service Coordinator: ______________________ **Phone:** ____________
Agency: ____________ Address ______________________

Dates important to follow:
Referral Date: ________ Initial IFSP Meeting Date: ________ Completed IFSP Date: ________
Day 0 Day 45- Evaluation completed Day 60- Signatures received

Other possible agencies or programs involved with child and/or family

☐ WIC ☐ MIHP ☐ IMH ☐ Early Head Start ☐ Great Parents Great Start ☐ Medicaid ☐ CSHCS

Office use only
Justification for not completing the Initial IFSP Meeting within 45 days from the date of referral:
☐ Child unavailable ☐ External reports not received ☐ Family issues ☐ Natural Disaster ☐ Personnel unavailable
☐ Other
Explain the justification checked: ______________________

Family Strengths, Needs, and Priorities

Child's Legal Name: ______________________ Person interviewed: ____________________ Date of interview: ___________

What is your child's typical day like? Who is he/she usually with? What does he/she play with?

On most days, what part of the day is the most enjoyable? The most difficult? Why?

What people, supports or resources are helpful or would be helpful to your family? What resources do you currently have?

What are some activities you enjoy doing with your child and family? What activities are stressful?

What concerns do you have with your child?

Do you have concerns about your child's ability to: (check all that apply; then number your top priorities)

☐ Get around (crawl, walk, run)
☐ Think, learn, play with toys
☐ Have fun with other children
☐ Bathe, undress, dress, go to bed
☐ Calm down, quiet down
☐ See or hear
☐ Talk and listen
☐ Feed, eat
☐ Relate in a meaningful way with other family members
☐ Look at you
☐ Sleep
☐ Other

I want to know more about: (check all that apply)
☐ Meeting with other families to share information, or to learn about a child like mine.
☐ Finding or working with doctors or other specialists.
☐ Planning for the future; what to expect.
☐ People who can help me at home or care for my child so I/we can have a break.
☐ Information on my child's condition, what it means.
☐ Resources to help cover the costs of my child's special needs (e.g. equipment, supplies ...).
☐ Housing, clothing, jobs, education, food, telephone.
☐ Other: ____

Child's Current Developmental Status

Date:____________

Child's Legal Name: Age: Corrected Age (for premature infants):

Eligibility must be based on the integration of all four of the following sources of information. (Check all that have been used):

☐ **Developmental History** ☐ **Health Status** ☐ **Observation of Child and Parent Interaction** ☐ **Developmental Evaluation**

☐ See the Integrative Report incorporating the above four sources. ☐ Date of Multidisciplinary Evaluation: __________

Area	Present Level of Development: Parent Input	Present Level of Development: Result of Developmental Evaluation	Method/Tool/Date Person Completing the Area Name/Title	Family Priority
Health ☐ See Attached Report		☐ How affects participation in Early Intervention activities		
Hearing ☐ See Attached Report		☐ Language needs considered		
Vision ☐ See Attached Report		☐ Braille needs considered		
Fine Motor ☐ See Attached Report				
Gross Motor ☐ See Attached Report				
Cognitive/Thinking ☐ See Attached Report				
Communication ☐ See Attached Report		☐ English proficiency considered; Sign language		
Social/Emotional ☐ See Attached Report		☐ Positive Behavioral Supports Considered		
Adaptive ☐ See Attached Report		☐ Assistive Technology Considered		

Eligibility Determination

Child's Legal Name:____ Birth Date: ____________

(Check A or B)

☐ **A.** This child meets the eligibility for early intervention services (Check all that apply)

☐ 1. A **Developmental Delay** in at least one of the following area(s): (Check all that apply)

☐ Gross Motor ☐ Fine Motor ☐ Communication ☐ Cognitive
☐ Social/Emotional ☐ Self-Help ☐ Physical development including hearing & vision

☐ 2. An **Established Condition** which has a high probability of resulting in a developmental delay. (Check all that apply)

☐ Chromosomal/Genetic
☐ Neurological Disorder
☐ Congenital Malformation
☐ Inborn Error of Metabolism
☐ Sensory Disorder including Hearing and/or Vision Deficiencies
☐ Atypical Development Disorder
☐ Severe Toxic Exposure
☐ Chronic Illness
☐ Severe Infectious Disease

☐ 3. **Special Education** (Specify Rule Number)

☐ Physical Impairment Rule # 340.1709
☐ Other Health Impairment Rule # 340.1709a
☐ Speech and Language Impairment Rule # 340.17 1 0
☐ Hearing Impairment Rule # 340.1707
☐ Vision Impairment Rule # 340.1708
☐ Early Childhood Developmental Delay Rule # 340.1711
☐ Severe Multiple Impairment Rule # 340.1714
☐ Autism Rule # 340.1715
☐ Cognitive Impairment Rule # 340.1705
☐ Other: ________________________________
☐ Other: ________________________________

☐ **B.** This child does not meet the eligibility criteria for *Early On.*

☐ Offer to re-screen child within six months.

☐ Offer community resources that might benefit the family:

____

☐ This information was given to the family on _____________

Participants in *Early On* who found the child ineligible

	Title
	Evaluator
	Evaluator
	Service Coordinator

☐ ***Early On*** IFSP Outcome and/or ☐ Special Education IEP Goal

Child's Legal Name: Current Date:

Concern of the Parent:

Present Status: (What is the child doing now? What has been tried? What is working?)

Goal/Outcome Statement: (What would you like to see happen for your child?)
The child (audience) will (behavior) what/at (condition or criteria) by (date)
Priority number: (Please circle) 1 2 3 4 5 6 7 (The priority number should match priorities identified on pages 2 and 3)

Goal #-__________

Steps or short term objectives: (At least 2 per goal)	*** Evaluation**	***Criterion**	*****Timeframe (needed to accomplishment this step)**
1.			
2.			
3.			
4.			

Strategies/Methods: (What methods or techniques will be used during the child's daily routines to meet this outcome?)

Progress Toward Outcome

Progress made: (To be evaluated at least every 6 months)

Date	Obj. 1	Obj. 2	Obj. 3	Obj. 4	Comments/ Status of Progress ****

* Evaluation	** Criterion	***Timeframe	****Status of Progress
D - Documented observation P - Parent(s) report R - Rating scale A - Assessment Tool	___ % Accuracy ___ Parent Satisfaction ___ Achievement level ___ Other (specify)	- 1 month - 2 months - 3 months - 6 months - 9 months	1 - Achieved/Maintained 2 - Progressing at rate sufficient to meet goal 3 - Progressing below a rate sufficient to meet goal - needs revision 4 - Partially accomplished 5 - Other (specify)

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Child's Legal Name: Current Date:

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Present Status: (What is the child doing now? What has been tried? What is working?)

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2.			
3.			
4.			

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Early Intervention Services

Child's Legal Name:________________________ Date: ____________

Service / Provider	Supports Outcome(s) #	How long/How often? Method (Indiv/Group)	Location 1. Home 2. Community Setting 3. Other	Projected Start Date/ End Date	Parent's Initials of each service	Payor
1			☐Yes Justification needed			
2			☐ Yes Justification needed			
3			☐ Yes Justification needed			
4			☐ Yes Justification needed			
5			☐ Yes Justification needed			

Natural environments means settings that are natural or normal for the child's age peers who have no disabilities (34CFR 303.18). The IFSP requires a "justification of the extent, if any, to which the services will not be provided in a natural environment" (IDEA section 636(d)(5) and (303.344(d)(ii). There must be a justification for each service not provided in the natural environment.

Justification: Service # ____

Justification: Service # ____

Justification: Service # ____

Other Supports and Services (Other resources, supports, services that assist the family)					
Service/Support	Supports Outcome Number	How long? How often?	Start/End Date	Location	Funding Source

Signature & Procedural Safeguards

(This signature page is to be used with every IFSP or IEP development or change.
Check the "Type" of IFSP/ IEP to indicate the purpose of this page.)

Child's Legal Name:_______________________________ Date: ____________

Type of IFSP or IEP

☐ Interim IFSP/Date: ____________
☐ Initial IFSP Date: ____________
☐ Completed IFSP Date: ____________
☐ 6 Month Review/Date: ____________
☐ Annual IFSP and/or IEP/Date: ____________
☐ Other Review/Date: ____________
☐ Transition Conference/Date:____________
☐ Transition/Date: ____________

Child Outcomes Review

☐ **Entry** ☐ **Annual** (optional) ☐ **Exit**

Tool Used:_______________________ Date: ____________

1. Child has positive social relationships.
☐ 1. Not Yet ☐ 2. ☐ 3. Emerging ☐ 4. ☐ 5. Somewhat ☐ 6. ☐ 7. Completely
Progress made: ☐ Yes ☐ No

2. Child acquires and uses knowledge and skills.
☐ 1. Not Yet ☐ 2. ☐ 3. Emerging ☐ 4. ☐ 5. Somewhat ☐ 6. ☐ 7. Completely
Progress made: ☐ Yes ☐ No

3. Child takes appropriate action to meet his/her needs.
☐ 1. Not Yet ☐ 2. ☐ 3. Emerging ☐ 4. ☐ 5. Somewhat ☐ 6. ☐ 7. Completely
Progress made: ☐ Yes ☐ No

Team Members and Contributors

Printed Name and Role	Signature	Agency	Phone/e-mail
		Parents	
		Service Coordinator	
		Lead Agency Rep.	
		LEA Representative	

Parent Consent **(Please check all that apply)**

☐ I/We, as parent(s)/guardian(s), have had *Early On* and/or Special Education explained to me/us including my/our rights and the possibility of 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 ☐ *Welcome to Early On® Guidebook* ☐ *Family Rights Guidebook*
☐ *The Individualized Family Service Plan Guidebook* ☐ *Transition Guidebook*
☐ *Procedural Safeguards for Special Education*

OR

☐ I/We do not agree with this IFSP or IEP.
☐ I/We decline *Early On* services.

Parent(s) Signature: Date:

Service Coordinator Signature: Date:

Special Educational Accommodations, Modifications and Considerations

(To be completed for IEP's only)

Child's Legal Name: Date:

☐ The IEP/IFSP Team has considered supplementary aids and services, program modifications, and supports for school personnel required for the child to attain the annual goals. The Team considered accessibility of physical facilities, specialized transportation, assistive technology devices, & assistive technology services.

Service	Frequency/Duration/Condition	Initial Date	Duration Date	Location

☐ This IFSP/IEP Team considered the need for a teacher endorsed in a particular category.

☐ How will the developmental needs of this child be addressed during the summer months?

IEP/IFSP Team Recommendation

☐ This child is Not eligible for special education programs/services.

☐ Outlines programs/services to be provided with the following **person assuring implementation**___________________

All programs/services/modifications will begin on ___________ end on ___________ and continue for: *(choose one)*

☐ One regular school year ☐ An adapted school year

☐ Other: (Specify)_______________________________ Rationale: ___________________________________

☐ One or more IEP/IFSP Team Members disagree with this recommendation. *(Complete & attach a dissenting report)*

IEP/IFSP **Commitment Signatures**

Resident District

The resident district assures that the least restrictive/natural environment has been fully considered: *(Choose all that apply)*

☐ **Agrees** with the recommendation of the IEP/IFSP Team and: *(check all that apply for **eligible** children)*

☐ **Assigns** this child to the following program/school & operating district: ____________________________

☐ **Authorizes** the non-resident district to assign an appropriate school/program and conduct post-initial IEP/IFSP Team meetings.

☐ **Does not agree** with the recommendation of the IEP/IFSP Team

Resident District Superintendent/Designee: Date:

Operating District

The non-operating district assures that the least restrictive/natural environment has been fully considered and: *(choose all that apply)*

☐ **Agrees** with the recommendation of the IEP/IFSP Team and: *check all that apply for eligible children)*

☐ **Assigns** this child to the following program/school____

☐ **Agrees** to conduct post-initial IEP/IFSP meetings.

☐ **Does not agree** with the recommendation of the IEP/IFSP Team

Operating District Superintendent/Designee: Date:

Parent/Guardian

I, as parent/guardian, ☐ have had Early On® and Special Education explained to me, ☐ have helped to develop this plan & understand its contents, ☐ have received a copy of & understand my Procedural Safeguards *(check all that apply)*

☐ I **Authorize** the sharing of information with agencies that will implement this plan.

☐ I **Agree** to the content and implementation of this plan, and its referrals

☐ I **Do not agree** with the IEP/IFSP

Parent/Guardian: Date:

Parent/Guardian: Date:

☐ Parent/Guardian did not attend. Report copy was sent by: Date: