
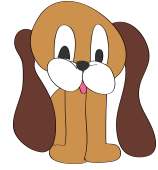


RI Early Intervention Individualized Family Service Plan

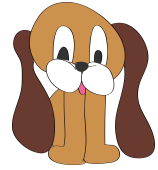
	
<p>Child's Name:</p> <p>DOB: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-binary</p> <p>Referral Date:</p> <p>ID#:</p> <p>Child's Address:</p> <p>Child's Primary Language:</p> <p>Primary Language Spoken at Home:</p>	<p>Parent/Guardian:</p> <p>Address:</p> <p>Phone #(s)</p> <p>Email:</p> <p>Best method of contact <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Email <input type="checkbox"/> Text Message</p> <p>Primary Language:</p> <p>Interpreter Required?: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Primary Care Physician:</p> <p>PCP Address:</p> <p>Phone #:</p> <p>Fax #</p> <p>Service Coordinator:</p> <p>Phone:</p> <p>Email:</p> <p>Parent Consultant:</p> <p>Phone:</p> <p>Email:</p>	<p>Parent/Guardian:</p> <p>Address:</p> <p>Phone #(s)</p> <p>Email:</p> <p>Best method of contact <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Email <input type="checkbox"/> Text Message</p> <p>Primary Language:</p> <p>Interpreter Required?: Yes No</p>
<p>Eligibility/IFSP Meeting Date: (Date the IFSP team meets to begin development of IFSP)</p> <p>Routines Based Assessment Method:</p> <p>Routines Based Assessment Date:</p> <p>IFSP Start Date:</p> <p>IFSP End Date:</p>	<p>Completed Review</p> <p>Periodic (1) Date:</p> <p>Annual (1) Date:</p> <p>Periodic (2) Date:</p> <p>Annual (2) Date:</p> <p>Periodic (3) Date:</p>

RI Early Intervention Screening for Hearing Loss or Change in Hearing Level



Child's Name			ID#			DOB			
Column 1			Column 2						
Yes	No		Yes	No	NA or Not Sure				
		Do you have any concerns about how your child hears?				Approximately how many spoken words or gestures does your child use consistently? words gestures			
	<input type="checkbox"/>	Do you have any concerns about your child's language development?				Compare this information to the developmental milestones expected for children this age. Any child with words/gestures like that of a younger child should be referred for a hearing assessment.			
	<input type="checkbox"/>	Has anyone else expressed concern about how your child hears? If yes, who?							
	<input type="checkbox"/>	Has anyone else expressed concerned about your child's language development? If yes, who?		<input type="checkbox"/>	<input type="checkbox"/>				
	<input type="checkbox"/>	Has your child had middle ear infections or fluid in the ears for more than 3 months?				At 2 months, did/does your child coo or make gurgling sounds <u>and</u> turn his/her head toward sounds?			
	<input type="checkbox"/>	Does your child have a medical condition associated with hearing loss (see a example list on back)?		<input type="checkbox"/>	<input type="checkbox"/>	At 4 months, did/does your child babble with expression and copy sounds he/she hears?			
	<input type="checkbox"/>	Has your child had meningitis?		<input type="checkbox"/>	<input type="checkbox"/>	At 6 months does your child respond to his/her name?			
	<input type="checkbox"/>	Has your child experienced head trauma or excessive exposure to noise?				At 9 months, did/does your child turn toward familiar voices and sounds in the environment?			
	<input type="checkbox"/>	Has your child experienced any serious illness requiring hospitalization?				At 12 months, did/does your child say single words such as "ma-ma", "da-da"?			
	<input type="checkbox"/>	Does your child have a craniofacial anomaly, such as cleft palate that was not identified at birth?		<input type="checkbox"/>	<input type="checkbox"/>	At 18 months, did/does your child follow or respond to simple questions? "Come here" "Where's your shoe?"			
						At 18 months, does/did your child say have at least 10 single words, e.g. "puppy", "milk", "cookie"			
						At 24 months, did/does your child use two or three word phrases to talk or ask for things?			

*If you answered **"yes"** to any questions in Column 1 and/or **"no"** to any question in Column 2, it is recommended that you schedule a comprehensive hearing test for your child by a licensed pediatric audiologist. Testing will ensure your child is hearing all the sounds we would expect. A copy of this hearing screening should be given to the audiologist.*



Based on the results of this assessment:

- We recommend your child receives a comprehensive hearing assessment with a pediatric audiologist** (enter FER on Evaluation Summary page)
- Parents/Guardian has received **RI Guide to Your Child's Hearing Assessment**, which includes a list of pediatric audiologists*
- We have learned your child is currently being followed by an audiologist** (enter FER on Evaluation Summary page)
Audiologist Name: Dr.
Child's next scheduled appointment is on
- No concerns have been identified at this time. Your child will continue with standard periodic screenings by their pediatrician and EI will revisit this screening at, or before the annual IFSP review (enter WNL on Evaluation Summary page)**

Parents/Guardian: If applicable, remember to give your consent for Early Intervention to obtain a copy of your child's audiologic report.

Are you unsure if your child passed their newborn hearing screen?

If your child was born in RI, results can be obtained from the RI Hearing Assessment Program (phone 401-277-3700, fax 401-921-6937). You can call directly, or your EI provider can assist you. If you would like your EI provider to obtain this information on your behalf, you will be asked to sign consent before the request can take place. If the child was born out of state and you are unaware if their child was tested or what the results were, you can consult www.infanthearing.org to obtain contact information for that state.

Does your child have a medical condition associated with hearing loss?

There are over 300 syndromes associated with hearing loss. This is a list those that are more common. All children with these diagnoses should be followed closely by a pediatric audiologist.

- | | | |
|--------------------------------|--------------------------------------|------------------------------|
| • Achondroplasia | • Fetal Alcohol Syndrome | • Stickler Syndrome |
| • Alport | • Goldenhar Syndrome | • Treacher Collins |
| • Apert | • Hunter Syndrome | • Trisomy 13 or 18 |
| • Branchio-Oto-Renal Syndrome | • Mitochondrial Conditions | • Trisomy 21 (Down Syndrome) |
| • Charcot-marie-Tooth | • Neurofibromatosis | • Turner Syndrome |
| • CHARGE Syndrome | • Pendred | • Usher Syndrome |
| • Crouzen or Cornelia de Lange | • Oculo-Auriculo-Vertebral Dysplasia | • Waardenburg Syndrome |

RI Early Intervention Screening for Vision Loss or Changes in Vision



Child's Name:			ID#	DOB			
Column 1			Column 2				
Yes	No		Yes	No	NA		
<input type="checkbox"/>	<input type="checkbox"/>	Do you have any concerns about your child's vision? If yes, please explain				At 0-3 months, did/does your child:	
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Smile at other people?	
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Look at their own hands?
<input type="checkbox"/>	<input type="checkbox"/>	Have you/other parent ever had a medical condition related to your eyes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Look at parent(s) as they enter the room?	
<input type="checkbox"/>	<input type="checkbox"/>	Do your child's eyes appear to cross, turn in or wander?				At 4 – 6 months, did/does your child?	
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Watch a ball drop on the floor and roll away?
<input type="checkbox"/>	<input type="checkbox"/>	Are your child's pupils or eyes different sizes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Look back and forth between 2 objects?	
<input type="checkbox"/>	<input type="checkbox"/>	Have you noticed any rapid back and forth movement of your child's eyes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Notice something small like a raisin when it is 12 inches away?	
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reach and grasp at toys?
<input type="checkbox"/>	<input type="checkbox"/>	Does your child press on or poke at their eye(s)?				At 7-9 months, did/does your child?	
<input type="checkbox"/>	<input type="checkbox"/>	Does your child tilt or turn their head in an unusual way when looking at something?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Look for dropped toys?	
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attempt to move toward an object that is at least 5 feet away?
<input type="checkbox"/>	<input type="checkbox"/>	Was your child born prematurely or on oxygen while in the hospital?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Try to grab hair, jewelry or glasses?	
<input type="checkbox"/>	<input type="checkbox"/>	Does your child ever bring objects very close to their face in order to see better?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pick up or attempt to pick up a small object?	
<input type="checkbox"/>	<input type="checkbox"/>	Does your child ever squint when in normal lighting? If yes, when?				At 10 – 18 months, does/did your child?	
<input type="checkbox"/>	<input type="checkbox"/>	Does your child have a health condition associated with vision loss (see examples on next page)? Or other diagnosis or medical concerns? If yes, please explain _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	React to facial expressions of others such as frowns or smiles?	
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Show an interest in picture books?
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reach in to a container and pull out objects easily?
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Notice objects or people outside through a window?
<p><i>If you answered "yes" to any questions in Column 1 and/or "no" to any question in Column 2, it is recommended that you schedule a comprehensive eye exam for your child by a pediatric optometrist or ophthalmologist. A copy of this vision screening should be given to the eye care provider, as well as your child's pediatrician.</i></p>							



Based on the results of this assessment:

- We recommend your child receives a comprehensive eye examination with a pediatric optometrist or ophthalmologist** (enter FER on Evaluation Summary page)
- Parents/Guardian has received **RI Guide to Your Child's Vision**, which includes a list of pediatric optometrists and ophthalmologists
- We have learned your child is currently being followed by an optometrist or ophthalmologist** (enter FER on Evaluation Summary page)
Optometrist /Ophthalmologist Name: Dr. _____
Child's next scheduled appointment is on _____
- No concerns have been identified at this time. Your child should continue with recommended screenings by their pediatrician and EI will revisit this screening at, or before the annual IFSP review** (enter WNL on Evaluation Summary page)

Parents/Guardian: If applicable, remember to give your consent for Early Intervention to obtain a copy of your child's eye examination report.

There are many medical conditions that can impact a child's vision. This is a list of some that will require a child to be closely followed by a pediatric ophthalmologist.

- Strabismus
- Congenital Cataracts
- Congenital Glaucoma
- Retinal Degeneration
- Optic Atrophy
- Tuberous Sclerosis
- Marfan syndrome
- Cerebral Palsy
- Osteogenesis Imperfecta
- Galactosemic
- Hypocystinuria
- CHARGE syndrome
- Trisomy 13
- Trisomy 18
- Down Syndrome
- Albinism

The American Academy of Ophthalmology and the American Association for Pediatric Ophthalmology and Strabismus recommend the following schedule for pediatric vision screening:

Newborn. An ophthalmologist, pediatrician, family doctor or other trained health professional should examine a newborn baby's eyes and perform a red reflex test (a basic indicator that the eyes are normal). An ophthalmologist should perform a comprehensive exam if the baby is premature or at high risk for medical problems for other reasons, has signs of abnormalities, or has a family history of serious vision disorders in childhood.

Infant. A second screening for eye health should be done by an ophthalmologist, pediatrician, family doctor or other trained health professional at a well-child exam between six months and the first birthday

Preschooler. Between the ages of 3 and 3½, a child's vision and eye alignment should be assessed by a pediatrician, family doctor, ophthalmologist, optometrist, orthoptist or person trained in vision assessment of preschool children.

American Academy of Ophthalmology 2019
<https://www.aao.org/eye-health/tips-prevention/children-eye-screening>

REQUIRED FOR INITIAL ELIGIBILITY ONLY OR OPTIONALLY IF CONCERNS ARISE

RI Early Intervention: Assessment for Vision Loss or Changes in Vision, 3.7.23
Portions of this screening are adapted from: Heiting OD, Gary (2017). Your Infant's Vision Development. Retrieved from <https://www.allaboutvision.com/parents/infants.htm>



RI Early Intervention Family Service Plan Evaluation Summary

Child's Name _____ **DOB** _____ **Age** _____ **ID** _____ **Date** _____

Where was the evaluation conducted?

Was the child's behavior and participation typical?

Evaluation Team (list names/roles and include family members):

Methods / Procedures Used For Evaluation/Assessment (check all that apply):
 Checklist *Review of medical record* *Observation* *Interview*

Standardized tool:

Additional information about methods/procedures used:

Scores: Indicate Standard Score (SS; this is the same as Composite Score)
Results: Indicate if 2 SD or 1.5 SD, WNL (Within Normal Limits) or SIF (Significant Impact on Functioning). If result is less than 1.5 SD, indicate <1.5 SD. Significant Impact on Functioning must be described in Child Outcomes Summary Section B. For Hearing and Vision use WNL or FER (Further Evaluation Recommended).
Note: 2 SD = SS of 70 or below, 1.5 SD = SS 71-77, and SS 85-115 is considered to be within normal limits.

Developmental Area Reviewed	Score	Results	Developmental Area Reviewed	Score	Results	Developmental Area Reviewed	Score	Results
Cognitive			Gross Motor Skills			Vision	N/A	
Expressive Communication			Social Emotional			Hearing	N/A	
Receptive Communication			Adaptive Skills			Family Circumstance	N/A	
Fine Motor Skills			Health	N/A				

Eligibility Type/Reason

1. **Eligible due to Single Established Condition**
 Eligibility Diagnosis: _____ ICD-10 Code: _____
2. **Eligible due to Significant Developmental Delay – 2 standard deviations in at least one area**
 Eligibility Diagnosis: _____ ICD-10 Code: _____
3. **Eligible due to Significant Developmental Delay – 1.5 standard deviations in at least two areas**
 Eligibility Diagnosis: _____ ICD-10 Code: _____
4. **Eligible due to Significant Developmental Delay – significant impact on child/family functioning in one or more areas**
 Eligibility Diagnosis: _____ ICD-10 Code: _____

5. **Not eligible**

Additional diagnoses that are relevant to EI services:

Diagnosis/ICD-10 Code: _____ Diagnosis/ICD-10 Code: _____
 Diagnosis/ICD-10 Code: _____ Diagnosis/ICD-10 Code: _____

RI Early Intervention Individualized Family Service Plan Child Outcomes Summary Form (COS) B

Child's Name:	DOB:	ID:	Date:
Information in this Child Outcome Summary provided by (list only; signatures not necessary)			
Information Provided By:	Relationship to Child:		
Information Provided By:	Relationship to Child:		
Information Provided By:	Relationship to Child:		
Information Provided By:	Relationship to Child:		

Outcome I: Positive Social Emotional Skills (Including Social Relationships)

Involves how the child relates to adults and other children, and for older children, how the child follows rules related to interacting with others. The outcome is measured based on how the child forms secure relationships with adults and children, expresses feelings, learns rules and expectations, and interacts socially.

- **Relating with caregivers** (*attachment, separation, regulation, respond to/initiate/sustain interactions, respond to caregiver's touch, track caregivers visually...*)
- **Attending to others in a variety of settings** (*awareness, caution, respond to/offer greetings, respond to own/others' names...*)
- **Interacting with peers** (*awareness, respond/initiate/sustain interactions, share, cope and resolve conflicts, play next to/with peers...*)
- **Adapting to changes in the environment or routines** (*transition between activities, respond to new/familiar settings/interactions, behave in ways to participate, follow rules...*)
- **Expressing own emotions and responding to the emotions of others** (*show pride/excitement/ frustration, display affection, acknowledge/ comfort others...*)

Skills expected of a child this age (age expected)

Skills like that of a younger child; lead to age-expected (immediate foundational)

Skills of a much younger child; earlier skills (foundational)

Other observations and information

RI Early Intervention Individualized Family Service Plan Child Outcomes Summary Form (COS) B

Outcome 2: Acquiring and Using Knowledge and Skills

Involves thinking and reasoning, remembering, problem solving, using symbols and language, and understanding the physical and social world. The outcome is measured based on a child's exploration and imitation, as well as his or her understanding of object permanence, symbolic representation, numbers, classification, spatial relationships, expressive language and communication, and for older children, early literacy.

- **Showing interest in learning** (*track objects/people, persist, show eagerness and awareness, imitate and repeat actions, explore environment...*)
- **Using problem solving** (*figure things out, trial and error, remember steps/actions, use purposeful actions, experiment with known and new actions...*)
- **Engaging in purposeful play** (*early awareness and exploration, functional object use, use of household objects, construction, pretend, make believe play scenarios...*)
- **Demonstrates cognitive and literacy concepts** (*discriminates between objects, shows visual preference, shifts attention, interest in, interacts with books, differences/associations among things, matching/sorting, size/color/shape/numbers, actions with pictures and books, early writing...*)
- **Uses language to communicate** (*babbling, progressing from sounds to words/signs, imitates others sounds/signs, points or gestures to communicate interest, words/signs to communicate thoughts and interest*)
- **Understanding questions asked and directions given** (*responds to verbal/signed gestures & requests, understand meaning of increasingly complex word/questions/directions...*)

Skills expected of a child this age (age expected)

Skills like that of a younger child; lead to age-expected (immediate foundational)

Skills of a much younger child; earlier skills (foundational)

Other notable observations and information

RI Early Intervention Individualized Family Service Plan Child Outcomes Summary Form (COS) B

Outcome 3: Taking Action to Meet Needs

Involves taking care of basic needs, getting from place to place, using tools like a fork, toothbrush, or crayon, and for older children, contributing to their own health and safety. The outcome is measured based on a child's ability to integrate motor skills to complete tasks, self-help skills (e.g., dressing, feeding, grooming, toileting, and household responsibilities), and "act on the world to get what one needs."

- **Moving around to meet needs** (early movements and control to rolling, sitting, crawling, walking, running, jumping, climbing)
- **Using materials for effect** (manipulating small items/toys, turning knobs, unscrewing lids, putting pieces in a puzzle, using tools, crayons)
- **Eating and drinking with increasing independence** (suck/swallow, chew, bite, finger feed, use utensils, hold bottle, drink from cups, amount type of food...)
- **Dressing and undressing with increasing independence** (assist with dressing, take off, put on shoes and clothes, undo/do fasteners...)
- **Diaper/toileting & washing with increasing independence** (lift legs, sit on potty, wash hands, brush teeth, help with bathing ...)
- **Communicating needs** (how does child indicate hunger, need for diaper change, sleep, express discomfort, hurt, need for help, request/reject food, express choice...)
- **Showing safety awareness** (avoid dangers – stairs, stove, road, seatbelt...)

Skills expected of a child this age (age expected)

Skills like that of a younger child; lead to age-expected (immediate foundational)

Skills of a much younger child; earlier skills (foundational)

Other notable observations and information

RI Early Intervention Individualized Family Service Plan Child Outcomes Summary Form (COS) C

Child's Name: <input style="width: 80%;" type="text"/>	DOB: <input style="width: 80%;" type="text"/>	ID: <input style="width: 80%;" type="text"/>	Date: <input style="width: 80%;" type="text"/>
--	---	--	--

How would you summarize this child's development in each outcome area? Review and select a statement for each outcome and record in the box below.

Relative to same age peers this child:

- has all the skills we would expect for a child his/her age. (7)
- has the skills we would expect for a child his/her age, however there are concerns that he/she may be on the border of not keeping up with same age peers. (6)
- shows many age expected skills, but also shows some functioning that might be described like that of a slightly younger child. (5)
- shows occasional use of some age expected skills, but more of his/her skills are not yet age expected. (4)
- is not yet using skills expected of his/her age but does use many important and immediate foundational skills upon which to build. (3)
- is showing some emerging or immediate foundational skills upon which to build. (2)
- has functioning that might be described as that of a much younger child. He/she shows some early skills but not yet any immediate foundational or age expected skills. (1)

Outcome	Summary Statement # <small>(Choose one for each Outcome)</small>	Exit Only: Has this child made progress in this outcome? <small>(Choose one for each Outcome)</small>
Positive Social Emotional Skills (Including Social Relationships)		<input type="checkbox"/> YES <input type="checkbox"/> NO
Acquiring and Using Knowledge and Skills		<input type="checkbox"/> YES <input type="checkbox"/> NO
Taking Action to Meet Needs		<input type="checkbox"/> YES <input type="checkbox"/> NO
No exit rating due to: <input type="checkbox"/> Child enrolled less than 6 months <input type="checkbox"/> Lack of information due to loss of contact with child/family		



RI Early Intervention Individualized Family Service Plan

Child and Family Outcomes

Child's Name	ID#	DOB
<p><i>Outcomes are like goals...they reflect the changes families would like to see happen for themselves and their children. They are based on family concerns and priorities and are related to the development of your child and supports and resources to support you and your family.</i></p> <p><i>Recommended format for writing child outcomes is: [child] will participate in [activity/routine]in order to [what participation will look like]. We will know this has been achieved when [measurement].</i></p> <p><i>Family outcomes are typically about acquisition of information, support, and resources, implementation of plans/ goals.</i></p>		
<p><i>Outcome</i></p>		
Date Written	Date Reviewed	Periodic /6 Mo. Annual IFSP
Other		
<p><i>Outcome</i></p>		
Date Written	Date Reviewed	Periodic /6 Mo. Annual IFSP
Other		
<p><i>Outcome</i></p>		
Date Written	Date Reviewed	Periodic /6 Mo. Annual IFSP
Other		
<p><i>Outcome</i></p>		
Date Written	Date Reviewed	Periodic /6 Mo. Annual IFSP
Other		



RI Early Intervention Individualized Family Service Plan

Child and Family Outcomes

Child's Name	ID#	DOB
<i>Outcome</i>		
Date Written Other	Date Reviewed	Periodic /6 Mo. Annual IFSP
<i>Outcome</i>		
Date Written Other	Date Reviewed	Periodic /6 Mo. Annual IFSP
<i>Outcome</i>		
Date Written Other	Date Reviewed	Periodic /6 Mo. Annual IFSP
<i>Outcome</i>		
Date Written Other	Date Reviewed	Periodic /6 Mo. Annual IFSP
<i>Outcome</i>		
Date Written Other	Date Reviewed	Periodic /6 Mo. Annual IFSP
<i>Outcome</i>		
Date Written Other	Date Reviewed	Periodic /6 Mo. Annual IFSP

RI Early Intervention Individualized Family Service Plan

Early Intervention Services

Child's Name:	DOB:	ID#:	Date:
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IFSP MEETING NOTICE

An IFSP meeting occurs when there are decisions to be made about starting, stopping, changing, or refusing Early Intervention services. Before holding an IFSP meeting, Early Intervention is required to provide you with written notice early enough to ensure that you, along with any other individuals you would like to have present, are able to attend. This is your notice that the following IFSP meeting will be held today.

- Interim** - to develop a temporary plan for children presumed eligible who need immediate services prior to a complete IFSP
- Initial** - to develop and complete the IFSP
- Update** - to add, end, or change IFSP services
- Periodic Review** - to review all outcomes, which may result in a review/revision of one or more services
- Annual Review** - to evaluate and revise the IFSP, including all outcomes and all services

EI has confirmed with the parent/guardian that this meeting notice was provided early enough for the family to attend.

Services and supports are determined after IFSP outcomes are developed.

Date Added	EI Service	Provider Name	Location	*Natural Setting (Y/N)	Method	Frequency (# times per week)	Intensity (length of session in minutes)	Duration (months)	Date Ended

*** If NO, complete "Plan for Providing Services in the Natural Environment"**

Services:	Location Codes:	Method:
<ul style="list-style-type: none"> <li style="width: 33%;">• Assistive technology <li style="width: 33%;">• Nutrition <li style="width: 33%;">• Social work <li style="width: 33%;">• Audiology <li style="width: 33%;">• Occupational therapy <li style="width: 33%;">• Speech/language therapy <li style="width: 33%;">• Family Training/Counseling <li style="width: 33%;">• Physical therapy <li style="width: 33%;">• Vision <li style="width: 33%;">• Nursing services <li style="width: 33%;">• Psychology 	<ul style="list-style-type: none"> <li style="width: 33%;">• H (Home) <li style="width: 33%;">• C (Community) <li style="width: 33%;">• CB (Center Based) <li style="width: 33%;">• EIGC (EI Group in the Community) <li style="width: 33%;">• CC (Childcare) <li style="width: 33%;">• N/A (Not Applicable) 	<ul style="list-style-type: none"> <li style="width: 33%;">• I (Individual) <li style="width: 33%;">• G (Group) <li style="width: 33%;">• GV (Group Virtual) <li style="width: 33%;">• IV (Individual Virtual)

Service Coordination is provided to coordinate services on the IFSP and could consist of home visits, telephone calls, and conversation with other providers. Early Intervention can provide interpretation, translation, and transportation services for families as needed to access EI services.

RI Early Intervention Individualized Family Service Plan Early Intervention Services

Child's Name:	DOB:	ID #:	Date:
Other services that are in place or are needed (medical, recreational, religious, or social services outside of EI that contribute to this plan):			
Program/Agency	Contact	Status	

IFSP Acknowledgement (*check one*)

I acknowledge the following:

- The services listed on this IFSP were determined to meet the current needs of my child and to support the outcomes we developed as an IFSP team.
- This is my prior written notice for the beginning of these IFSP services.
- [Procedural Safeguards](#) have been provided, reviewed, and explained to me.

Not applicable – a periodic review was conducted and there are no changes to IFSP services (no signature needed.)

IFSP Consent (*check one*)

I consent to Early Intervention services as written on this IFSP.

I consent to Early Intervention services as written on this IFSP **with the following changes:**

Not applicable – a periodic review was conducted and there are no changes to IFSP services (no signature needed.)

Parent/Guardian Signature: _____ **Date:** _____

RI Early Intervention Individualized Family Service Page Plan for Providing Services in the Natural Environment

Child's Name:	ID#	DOB
Explain why the child's outcome(s) could not be achieved in the child's natural environment. (What are the barriers? How does the team know?)		
How will the family participate in achieving this outcome? (How will the family be coached to practice these strategies and skills in everyday routines and activities?)		
What is needed to address this outcome within the child's typical daily routines and family activities? (Who is responsible? What is the timetable? How will the family be supported?)		
Review Date: <input type="checkbox"/> Continue <input type="checkbox"/> Change <input type="checkbox"/> Achieved Please summarize child's progress and changes that would be helpful to move toward achieving this outcome:		
Review Date: <input type="checkbox"/> Continue <input type="checkbox"/> Change <input type="checkbox"/> Achieved Please summarize child's progress and changes that would be helpful to move toward achieving this outcome:		