|  |  |  |
| --- | --- | --- |
|  | Agency LOGO | |
| **Child’s Name**:  **DOB**:  **Male  Female**  **Non-binary**  **Referral Date:**  **ID#:**  **Child’s Address**:    **Child’s Primary Language:**  **Primary Language Spoken at Home:** | | **Parent/Guardian**:  **Address:**    **Phone #(s)**  **Email**:  **Best method of contact  Home Phone**  **Cell Phone  Email  Text Message**  **Primary Language:**  **Interpreter Required?:  Yes  No** |
| **Primary Care Physician**:  **PCP Address:**  **Phone #**:  **Fax** #  **Service Coordinator**:  **Phone**:  **Email**:  **Parent Consultant**:  **Phone**:  **Email**: | | **Parent/Guardian**:  **Address:**    **Phone #(s)**  **Email**:  **Best method of contact  Home Phone**  **Cell Phone  Email  Text Message**  **Primary Language:**  **Interpreter Required?:  Yes  No** |
| **Eligibility/IFSP Meeting Date**: :  (Date the IFSP team meets to begin development of IFSP)  **Routines Based Assessment Method**:  **Routines Based Assessment Date:**  I**FSP Start Date:**  **IFSP End Date:** | | **Completed Review**  Periodic (1) Date:  Annual (1) Date:  Periodic (2) Date:  Annual (2) Date:  Periodic (3) Date: |
| If this is an Interim IFSP complete: Cover, Outcomes, Services and Interim Signature.  Complete IFSP must be finalized within 45 days of referral. | | |

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| **Child 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  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. | | |
|  |  | Do you have any concerns about your child's language development? | |
|  |  | Has anyone else expressed concern about how your child hears? If yes, who? | |
|  |  | Has anyone else expressed concerned about your child’s language development? If yes, who? | |  |  | |  | | Did your child pass his/her newborn hearing screening? | | |
|  |  | 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 and turn his/her head toward sounds? | | |
|  |  | Does your child have a medical condition associated with hearing loss (see a example list on back)? | |  |  | |  | | At 4 months, did/does your child babble with expression and copy sounds he/she hears? | | |
|  |  | Has your child had meningitis? | |  |  | |  | | At 6 months does your child respond to his/her name? | | |
|  |  | 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? | | |
|  |  | 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"? | | |
|  |  | Does your child have a craniofacial anomaly, such as cleft palate that was not identified at birth? | |  |  | |  | | 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 1and/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](file:///C:\Users\bpanicci\AppData\Roaming\AppData\Local\Microsoft\Windows\Temporary%20Internet%20Files\EI%20Paperwork\EI%20Paperwork\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.

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| * 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 |

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| **Child Name:** | | | **ID#** | | | | **DOB** |
| **Column 1** | | | **Column 2** | | | | |
| **Yes** | **No** |  | **Yes** | **No** | **NA** |  | |
|  |  | Do you have any concerns about your child’s vision? If yes, please explain  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | | | **At 0-3 months, did/does your child:** | |
|  |  |  | Smile at other people? | |
|  |  |  | Look at their own hands? | |
|  |  | Have you/other parent ever had a medical condition related to your eyes? |  |  |  | Look at parent(s) as they enter the room? | |
|  |  | Do your child’s eyes appear to cross, turn in or wander? |  | | | **At 4 – 6 months, did/does your child?** | |
|  |  |  | Watch a ball drop on the floor and roll away? | |
|  |  | Are your child’s pupils or eyes different sizes? |  |  |  | Look back and forth between 2 objects? | |
|  |  | Have you noticed any rapid back and forth movement of your child’s eyes? |  |  |  | Notice something small like a raisin when it is 12 inches away? | |
|  |  |  | Reach and grasp at toys? | |
|  |  | Does your child press on or poke at their eye(s)? |  | | | **At 7-9 months, did/does your child?** | |
|  |  | Does your child tilt or turn their head in an unusual way when looking at something? |  |  |  | Look for dropped toys? | |
|  |  |  | Attempt to move toward an object that is at least 5 feet away? | |
|  |  | Was your child born prematurely or on oxygen while in the hospital? |  |  |  | Try to grab hair, jewelry or glasses? | |
|  |  | Does your child ever bring objects very close to their face in order to see better? |  |  |  | Pick up or attempt to pick up a small object? | |
|  |  | Does your child ever squint when in normal lighting? If yes, when?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | | | **At 10 – 18 months, does/did your child?** | |
|  |  | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  | React to facial expressions of others such as frowns or smiles? | |
|  | |  |  |  | Show an interest in picture books? | |
|  |  |  | Reach in to a container and pull out objects easily? | |
|  |  |  | Notice objects or people outside through a window? | |
| *If you answered* ***“yes” to any questions in Column 1and/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.* | | | | | | | |

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| ***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 | | * Optic Atrophy | * Osteogenesis Imperfecta | * Trisomy 13 | |
| * Congenital Cateracts | | * Tuberous Sclerosis | * Galactosemic | * Trisomy 18 | |
| * Congenital Glaucoma | | * Marfan syndrome | * Hypocystinuria | * Down Syndrome | |
| * Retinal Degeneration | | * Cerebral Palsy | * CHARGE 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>

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| **Child Name:** | **ID#** | **DOB** | **Date:** /     / |
| **Where was the evaluation conducted?**       **Evaluation Date**:  **Evaluation Team (include role and/or credentials:**              **Family/Caregivers who were present:**              **Was the child’s behavior and participation similar to what parents,/caregivers typically see?**  **Yes  No** **If not, please explain.**        **Method**s **/ Procedures Used For Evaluation/Assessment: Check all that apply:**  Standardized tool        Review of medical record  Observation  Interview with  Additional Information about methods/procedures: | | | |
| **Eligible:** This child meets the eligibility criteria for early intervention services.  **Check #1 OR #2**  **1.**  **Single Established Condition (Specify)**  Primary Reason For Eligibility       ICD-10 Code:  Secondary Reason for Eligibility:       ICD-10 Code:  **2.**  **Significant Developmental Delay (Select Eligibility Category a, b, or c )**  Primary Reason For Eligibility:       ICD-10 Code:  **a) A delay of 2 standard deviations in at least one of the following area(s)**  Cognitive  Gross Motor  Fine Motor  Expressive Communication  Receptive Communication  Social Emotional  Adaptive Skills  **b) A delay of 1.5 standard deviations in at least two of the following area(s)**  Cognitive  Gross Motor  Fine Motor  Expressive Communication  Receptive Communication  Social Emotional  Adaptive Skills  **c) There is a significant impact on child/family functioning in the following area(s)**  Cognitive  Gross Motor.  Fine Motor  Expressive Communication  Receptive Communication  Social Emotional  Adaptive Skills  Vision Loss  Hearing Loss  Other Health  Family Circumstance | | | |
| **Child does not meet the eligibility criteria for Early Intervention services**  *For children who are not eligible, summarize child’s present levels of development and functioning on the Child Outcome Summary Form B (COS B). Include observations and information that addresses the reason for referral and parent concerns.*  **Family declined Early Intervention services** | | | |
| *See following page for Evaluation/Assessment Results* | | | |

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| **Child’s Name:** | | | **DOB:**      /     / | | | **ID:** | | **Date:** /     / | | |
| **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 **NCT** to indicate **N**o **C**oncern at this **T**ime or **FER** to indicate **F**urther **E**valuation **R**ecommended.  *Please note: 2 SD below mean = (SS=70 or below), 1.5 SD below mean = (SS=71-77)* *and in general, Standard Scores (SS) between 85 and 115 are 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 |  |
| Receptive Communication |  |  | | Social Emotional |  |  | Hearing | | N/A |  |
| Expressive Communication |  |  | | Adaptive Skills |  |  | Family Circumstance | | N/A |  |
| Fine Motor Skills |  |  | | Health | N/A |  |  | | | |
| **Response to Referral Source:** Has the parent signed consent to share these results with the referral source  Yes  No  N/A | | | | | | | | | | |

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| **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: | |

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| **Outcome 1: 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 |
|  |
| **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 |
|  |
| **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 |

| **Child Name** | **ID#** | **DOB** | **Date** |
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***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)

• Relative to same age peers, this child 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)

• Relative to same age peers, this child shows many age expected skills, but also shows some functioning that might be described like that of a slightly younger child. (5)

• Relative to same age peers, this child shows occasional use of some age expected skills, but more of his/her skills are not yet age expected. (4)

• Relative to same age peers, this child is not yet using skills expected of his/her age but does use many important and immediate foundational skills upon which to build. (3)

• Relative to same age peers, this child is showing some emerging or immediate foundational skills upon which to build. (2)

• Relative to same age peers, this child’s functioning 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)

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| Outcome | | Numerical Rating (Chose one for each Outcome) | Exit Only:  Has this child made progress in this outcome?  (Choose one for each Outcome) |
| 1 | **Positive Social Emotional Skills (Including Social Relationships)** |  | YES  NO |
| 2 | **Acquiring and Using Knowledge and Skills** |  | YES  NO |
| 3 | **Taking Action to Meet Needs** |  | YES  NO |
| No *exit* rating due to:  Child enrolled less than 6 months  Lack of information due to loss of contact with child/family | | | |

| **Child Name** | **ID#** | **DOB** | **Date** |
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| *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.*  *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].*  *Family outcomes are typically about acquisition of information, support, and resources, implementation of plans/ goals.* | | | |
| *Outcome*  **Date Written** **Date Reviewed**  Periodic /6 Mo.  Annual IFSP  Other**Parent Initials** | | | |
| *Outcome*  **Date Written       Date Reviewed**  Periodic /6 Mo.  Annual IFSP  Other **Parent Initials** | | | |
| *Outcome*  **Date Written       Date Reviewed**  Periodic /6 Mo.  Annual IFSP  Other **Parent Initials** | | | |
| *Outcome*  **Date Written       Date Reviewed**  Periodic /6 Mo.  Annual IFSP  Other **Parent Initials** | | | |
| *Outcome*  **Date Written       Date Reviewed**  Periodic /6 Mo.  Annual IFSP  Other **Parent Initials** | | | |
| *Outcome*  **Date Written       Date Reviewed**  Periodic /6 Mo.  Annual IFSP  Other **Parent Initials** | | | |
| *Outcome*  **Date Written       Date Reviewed**  Periodic /6 Mo.  Annual IFSP  Other **Parent Initials** | | | |
| *Outcome*  **Date Written       Date Reviewed**  Periodic /6 Mo.  Annual IFSP  Other **Parent Initials** | | | |
| *Outcome*  **Date Written       Date Reviewed**  Periodic /6 Mo.  Annual IFSP  Other **Parent Initials** | | | |
| *Outcome*  **Date Written       Date Reviewed**  Periodic /6 Mo.  Annual IFSP  Other **Parent Initials** | | | |

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| **Child’s Name:** | | | | **ID#:** | | | | | | | | | **DOB** | | | | |
| Check and date applicable area  Interim:        Initial:        Annual: | | | | | | | | | | | Update: | | | | | | |
|  | *Services and supports are determined after IFSP outcomes are developed.* | | | | | | | | | | | | | | | |  |
| **Date Added** | **EI Service** | **Provider** (Name) | | | **Location** | | **Natural Setting**  Yes / No | **Method**  **\***  I/G | | **Frequency**  (# of timesper wk/mo) | | | **Intensity**  (length of session) | | **Duration** (months) | **Date Ended** | |
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| **\* If NO, complete page 12 “Plan for Providing Services in the Natural Environment”** | | | | | | | | | | | | | | | | | |
| **Services:**  • Assistive technology  • Audiology  • Family Training/Counseling  • Nursing services  • Nutrition | | | • Occupational therapy  • Physical therapy  • Psychology  • Social work  • Speech/language therapy  • Vision | | | **Location Codes:**  ***H*** *(Home)* ***C*** *(Community)*  ***EIGC*** *(EI Group in the Community)*  ***CB*** *(Center Based)*  ***N/A*** *(Not Applicable)* | | | | | | **Method:**  **I** *(Individual)*  **G** *(Group)* | | | | | |
|  | Service Coordination is provided to coordinate services on the IFSP and could consist of home visits, telephone calls, and conversations with other providers. Early Intervention is able to provide interpretation, translation, and transportation services for families as needed to access EI programs and services. | | | | | | | | | | | | | | | | |
|  | **Services that are in place or are needed:** (services such as medical, recreational, religious or social, while not covered by Early Intervention, contribute to this plan) | | | | | | | | | | | | | | | | |
|  | **Program/Agency** | | | | | | | | **Contact** | | | | | **Status** | | | |
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|  | **Complete this Section for Updates and Annual IFSP Review Only**  Parental Consent: I understand and agree to the changes in the IFSP services listed above. I also understand that this is my prior written notice to starting the services listed above.  Parent/Guardian Signature**:** Date | | | | | | | | | | | | | | | |  |

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| **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:**  Continue  Change  Achieved  Please summarize child’s progress and changes that would be helpful to move toward achieving this outcome: |
| **Review Date:**        Continue  Change  Achieved  Please summarize child’s progress and changes that would be helpful to move toward achieving this outcome: |

**Acknowledgement of the IFSP**

**Child’s Name:       ID#       DOB**

I give my consent to implement this Individualized Family Service Plan for my child and family as written.

I give my consent to implement this Individualized Family Service Plan for my child and family with the following changes:

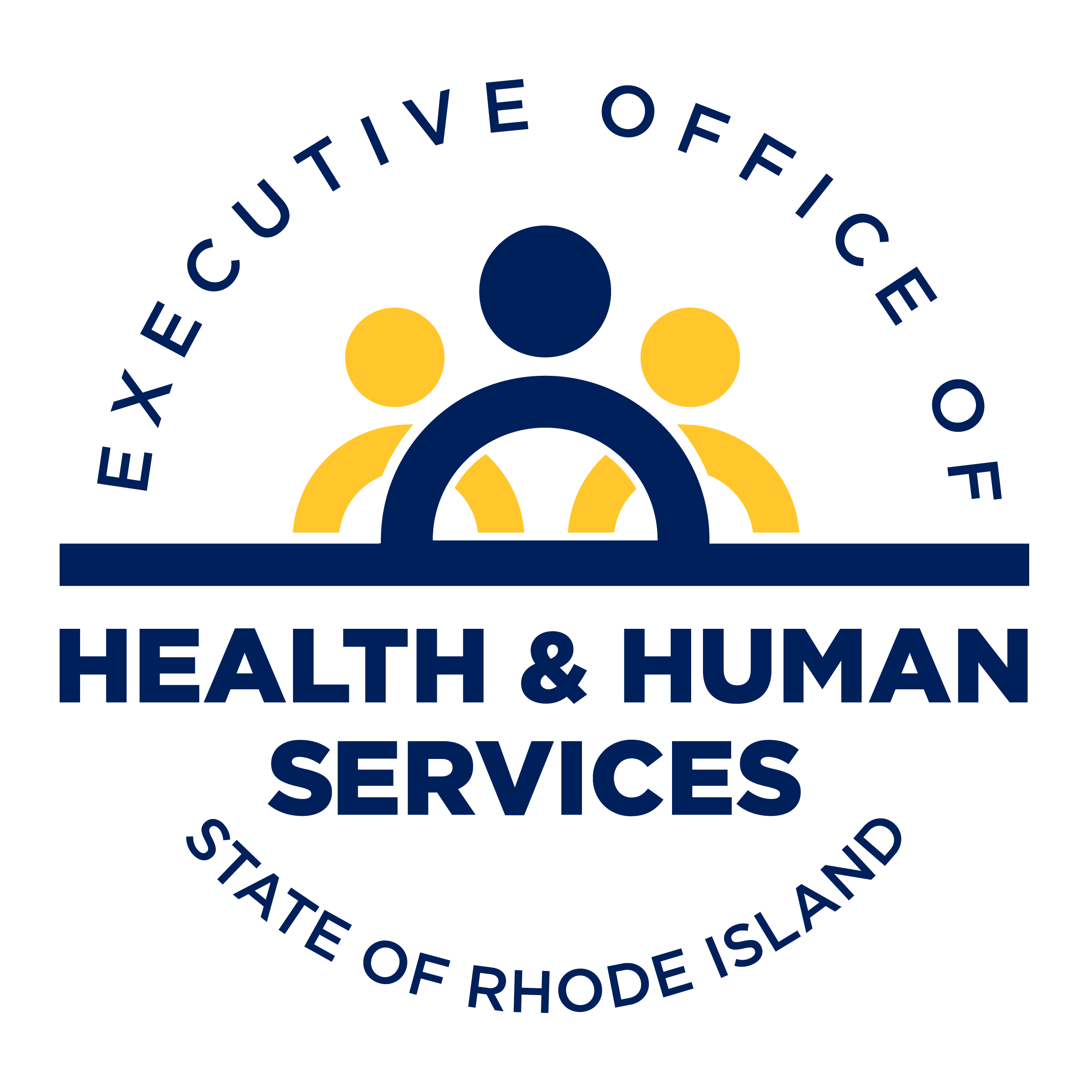
I understand that early intervention services will be paid by private health insurance, Medicaid or state funds.

I understand that this is my prior written notice to begin the services listed on the IFSP.

I have received a copy of my procedural safeguards. These rights have been explained to me and I understand them.

Parent/Guardian Signature:       Date:

Other Team Member:       Date:

****

**~For Interim IFSPs Only~**

I understand that this is an Interim IFSP and that it is a temporary plan developed for children who are eligible for Early Intervention and are in need of immediate services. I also understand that a full IFSP still needs to be completed within 45 days from my referral date.

Parent’s initials:       Date: