Individualized Family Service Plan (IFSP)

for the family of _____ born on ___/___/___ residing with _____.

Mother	Father	Guardian or Caregiver
Name:_____	Name:_____	Name:_____
Address:_____	Address:_____	Address:_____
_____	_____	_____
Phone: (H)_____ (W)_____	Phone: (H)_____ (W)_____	Phone: (H)_____ (W)_____

IFSP Timeline (Enter date of each event.) **This IFSP begins ___/___/___ and ends ___/___/___.**

Referral	Initial Evaluation	Part C Eligibility	Initial or Interim IFSP	Review/Revision	Re-Evaluation/ Assessment	Annual Renewal	Transition Plan

Plan Developers/Signatures

The following individuals have contributed to the development of this IFSP. Each individual understands and agrees to carry out the plan as it applies to their role in providing services. The parents have received and been informed of all procedural safeguards. All team members understand that the IFSP may be opened for revision at any time by request of any team member.

Title/Role	Printed Name	Signature (if present)	Date	Date/Initial Changes
Parent/Guardian:	_____	_____	___/___/___	___/___/___
Parent/Guardian:	_____	_____	___/___/___	___/___/___
Family Service Coordinator:	_____	_____	___/___/___	___/___/___
_____	_____	_____	___/___/___	___/___/___
_____	_____	_____	___/___/___	___/___/___
_____	_____	_____	___/___/___	___/___/___
_____	_____	_____	___/___/___	___/___/___

Anyone who disagrees with the IFSP, please explain what part of the IFSP you disagree with and sign below. Attach an additional page if needed.

Signature_____ Date_____

Top copy to program; second copy to parent; photocopies to all other IFSP team members

Information about _____'s development and strengths at the age of _____(adjusted age of_____)

Evaluation/assessment tools and methods used:

Present level of development ***(strengths and areas to work on):***

Moving *(gross motor):*

Using hands *(fine motor):*

Thinking/learning *(cognitive):*

Understanding/talking *(communication):*

Getting along with others *(social/emotional):*

Doing things for him/herself *(adaptive):*

Health and Medical Information *(List screening or evaluation dates, concerns and other pertinent information.)*

Vision	Behavioral Health
Hearing	Medication(s)
Immunizations	Nutrition
Dental	Other

Family concerns/priorities for child's growth and development:

Family resources/natural supports:

Natural environments:

Service Location

Primary:

Others:

If services cannot take place in natural setting or environment state reason.

Top copy to program; second copy to parent; photocopies to all other IFSP team members

Summary of Services

Service	Provider's Name	Service Setting/Location	How Often (visits/month)	Minutes/ visit	Start Date	End Date	Cost per unit of service	Payer

Service Options:

1. Assistive Technology
2. Audiological Services
3. Family Training/Support
4. Health Services
5. Hearing Services
6. Medical Diagnostic Services
7. Nursing Services
8. Nutrition Services
9. Occupational Therapy
10. Physical Therapy
11. Psychological Services
12. Respite
13. Service Coordination
14. Social Work Services
15. Speech/Language Therapy
16. Transportation
17. Special Instruction
18. Vision Services
19. Other (Specify)

Description of outcomes developed in partnership with _____'s family.

Date and Type of Outcome*	What We Want To Happen Outcomes / Goals	How We Will Do It Strategies / Methods / Materials	Who Will Do It Person(s) Responsible	Family's Evaluation Date / Rating**

***Type of Outcome:** I. Health/Medical II. Educational/Developmental III. Individual/Family Supports

****Family's Evaluation of Progress Rating:**
1. No longer needed 2. Keep working on it 3. Achieved

Description of outcomes developed in partnership with _____'s family (continued).

Date and Type of Outcome*	What We Want To Happen Outcomes / Goals	How We Will Do It Strategies / Methods / Materials	Who Will Do It Person(s) Responsible	Family's Evaluation Date / Rating**

***Type of Outcome:** I. Health/Medical II. Educational/Developmental III. Individual/Family Supports

****Family's Evaluation of Progress Rating:**
1. No longer needed 2. Keep working on it 3. Achieved

Top copy to program; second copy to parent; photocopies to all other IFSP team members

Summary of Services

Service	Provider's Name	Service Setting/Location	How Often (visits/month)	Minutes/ visit	Start Date	End Date	Cost per unit of service	Payer

Service Options:

1. Assistive Technology
2. Audiological Services
3. Family Training/Support
4. Health Services
5. Hearing Services
6. Medical Diagnostic Services
7. Nursing Services
8. Nutrition Services
9. Occupational Therapy
10. Physical Therapy
11. Psychological Services
12. Respite
13. Service Coordination
14. Social Work Services
15. Speech/Language Therapy
16. Transportation
17. Special Instruction
18. Vision Services
19. Other (Specify)

Top copy to program; second copy to parent; photocopies to all other IFSP team members