

INDIVIDUALIZED FAMILY SERVICE PLAN

Child's Name: _____
 Birthdate: _____

IFSP Meeting Date: _____
 IFSP Type: Initial Annual
 Designated Service Coordinator: _____
 Service Coordinator Phone #: _____

Six Month Review
 Annual IFSP
 Additional Review Dated

Date Due Date Completed

_____ _____ _____ _____ _____ _____
 m/d/y m/d/y m/d/y m/d/y m/d/y m/d/y

Date Due Date Completed

Transition Dates

Notification of Local Education Agency (LEA) by age two. _____
 Planning Conference with Parent/s, Lead Agency, LEA and other Service Providers, as appropriate. _____
 (At least 90 days, or up to 6 months prior to child's third birthday) _____
 Transition to LEA, as appropriate. _____

Natural Environments/Settings

To the maximum extent appropriate, services will be provided in natural environments, including the home, and community settings that are natural or normal for the child's age peers who have no disabilities. Natural environments for young children are those environments/situations that are within the context of the family's lifestyle – their home, their culture, daily activities, routines and obligations. Services will only be provided in settings not identified as the natural environment when it is determined that the desired outcome/s cannot be satisfactorily achieved within the natural environment of this child and family.

The natural environment for _____ includes the following places/settings:

Page One: COVER PAGE

Enter

Child's Name (first, middle, last)
Child's Birthdate

IFSP Meeting Date – date of this meeting
IFSP Type – check if Initial or Annual
Designated Service Coordinator – name and agency
Service Coordinator's Phone #

Planned **Six Month Review** date and **Annual IFSP** date – enter the approximate Date Due and, later, enter the Date Completed (actual date the meeting was completed.)

Additional Review Dates – enter the actual date(s) of occurrence(s).

Transition Dates

Notification of Local Education Agency, Planning Conference, and Transition to LEA – enter the approximate due dates and, later, the actual dates completed.

Natural Environment/Settings

Enter the name of the child, and list or describe places and settings the team, including the family, has identified as natural environments for the child.

Page Two: IDENTIFYING INFORMATION

Enter **Child's Name, Birthdate, Social Security Number, Address, Phone Number.** Enter **Parent's Name(s)** – the natural or adoptive parent and **Parent's Address**, if different from child's.

Eligibility

Enter a check next to the Part C eligibility which indicates the Part C eligibility criteria the child meets (check only one.) If eligible for DMR and/or CSS, check the appropriate box.

Referral

Enter the date of referral and state the specific agency, professional, or person making the referral.

Documentation (To be completed at the end of the meeting)

All members of the IFSP team should

1. Sign (if team member contributed but was not present, see #4.)
2. Enter the agency/title of the team member.
3. Enter date – the date of the meeting.
4. If team member contributed/not present at the IFSP meeting, print the name in the signature column and describe the method of contribution (conference call, written input, telephone call, etc.)
5. If team member fully agrees with the IFSP, check under "Fully Agree." If team member disagrees with part of the IFSP, use the space indicated to document area(s) of concern. Attach additional pages if necessary.

Designated Service Coordinator/Agency and Rationale

Enter the name of the person/agency the team selected and the rationale the team used in selecting this person.

Informed Parental Consent

Parent check the appropriate boxes (each must be checked yes.) Parent(s) signature indicates that procedural safeguards have been followed.

IDENTIFYING INFORMATION

Child's Name: _____

Child's Birthdate: _____ Child's Social Security #: _____

Child's Address: _____

_____ Street

City: _____ TN Zip: _____

Phone: _____ County: _____

Parent's Name(s): _____

Parent's Address (if different from child): _____

_____ Street

City: _____ TN Zip: _____

Phone: _____

	Part C/TEIS/TIPS	DMR	CSS
Eligibility	From Tennessee' Definition of Developmental Delay Meets: (check if applicable) % of Delay <input type="checkbox"/> Diagnosed Condition <input type="checkbox"/> Informed Clinical Opinion <input type="checkbox"/>	DMR <input type="checkbox"/>	CSS <input type="checkbox"/>
	Referral	_____ m/d/y _____ Source	_____ m/d/y _____ Source

DOCUMENTATION

IFSP Team Member – If present, sign If not present, list member's name	Agency/Title	Date	Contributed/ not present/method	Fully Agree	Area(s) of Concerns/ Comments
(Service Coordinator who organized this IFSP meeting)					
(Parent)					
(Parent)					
(Evaluator/Assessor)					

Designated Service Coordinator/Agency and Rationale

Name	Agency	Address	Phone #	Rationale
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Informed Parental Consent				
yes	no			
<input type="checkbox"/>	<input type="checkbox"/>	I am the parent/legal guardian/Department of Education trained surrogate parent of this child.		
<input type="checkbox"/>	<input type="checkbox"/>	I have been informed of & understand my rights as a parent in Tennessee under Part C Regulations. I have received a copy of <u>Rights of Infants and Toddlers with Disabilities</u> .		
<input type="checkbox"/>	<input type="checkbox"/>	I have participated in the development of the IFSP and understand its contents.		
<input type="checkbox"/>	<input type="checkbox"/>	I agree to its implementation to the degree noted above.		
Parent		Date	Parent	
			Date	

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Pages Three and Four: PRESENT LEVELS OF DEVELOPMENT

Record, next to the word "By," the name of the professional(s) who conducted the formal or informal screening, evaluation, or assessment which provided the information for the present levels of development. Enter the Date of the procedure and the child's Chronological Age at the time of the procedure. If the child was at least four weeks premature and under the age of two, enter the Adjusted Age. A narrative statement must be provided which records the strengths and needs of the child in each area of development. Test results should be reported in quantitative form (age level, percentiles, etc.). If the adjusted age is less than zero, the quantitative form of test results is not required.

Record the strengths and needs of the child in the developmental areas, based on professionally acceptable, objective criteria. This information, along with the family's resources, priorities, and concerns, will be used in determining the major outcomes. The "Other" space may be used for any additional information, including the family's assessment of the child's present levels of functioning (especially if the family has chosen not to have a Summary of the Family Resources, Priorities, and Concerns discussed at the IFSP meeting.)

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PRESENT LEVELS OF DEVELOPMENT

Child's Name

(Include a statement of functional strengths & needs in each area)

Health Date	Chron. Age <u>Strengths</u>	By (Adj. Age)	 - - - 	<u>Needs</u>
Vision Date	Chron. Age <u>Strengths</u>	By (Adj. Age)	 - - - 	<u>Needs</u>
Hearing Date	Chron. Age <u>Strengths</u>	By (Adj. Age)	 - - - 	<u>Needs</u>
Physical Development-Gross Motor Date	Chron. Age <u>Strengths</u>	By (Adj. Age)	 - - - 	Instrument
				<u>Needs</u>

Physical development/Fine Motor	By	Instrument	
Date	Chron. Age	(Adj. Age)	
<u>Strengths</u>	 		<u>Needs</u>

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Child's Name _____

PRESENT LEVELS OF DEVELOPMENT (Continued)
 (Include a statement of functional strengths & needs in each area)

Page Five: SUMMARY OF FAMILY RESOURCES, PRIORITIES, AND CONCERNS RELATED TO ENHANCING THE DEVELOPMENT OF THE CHILD

Information given in this summary is to reflect the **Resources, Priorities, and Concerns** of the family as identified by the family. The assessment is voluntary on the part of the family. The assessment should come from multiple sources which could include focused interviews, informal interviews, surveys.

Indicate, by checking wither “yes” or “no” in the statements at the top of the page, the family’s decision concerning participation in a voluntary family-directed assessment and the inclusion of the voluntary family-directed assessment information in the IFSP.

Enter the type(s)/method(s) of family assessment used, the date(s) that the family assessment(s) took place and the names of all who paricipated in the assessment process, including family members and professionals.

Enter in narrative or list form, a summary of

1. **Family Resources** that are available to the family, including formal and informal supports systems, educational resources, personal resources of family members (for example, the mother does not work outside the home and is very motivated to take her child and has time readily available to take her child to needed appointments, or the family is aware of their financial situation and is willing to accept financial help if it can secured.)
2. **Priorities** of the family—those things which are most important for the child and family.
3. **Concerns** of the family, including concerns the family has regarding their ability to cope with the child's situation (for example, the family has a low income and is very concerned about its ability to pay for services their child needs.)

Child's Name _____

SUMMARY OF FAMILY RESOURCES, PRIORITIES, AND CONCERNS RELATED TO ENHANCING THE DEVELOPMENT OF THE CHILD

yes no

- Family agreed to a voluntary family-directed assessment.
- Family agreed to the inclusion of the voluntary family-directed assessment in the IFSP.

Type(s)/method(s) of Family Assessment Used: _____

Date(s) of Family Assessment: _____

Participants _____

Family Resources	Family Priorities	Family Concerns
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Page Six: OUTCOME/ACTION STEPS

Major Outcomes

Based on information discussed prior to and during the IFSP meeting and documented on Page Two (Present Levels of Development) and on Page Three (Summary of Family Resources, Priorities, and Concerns Related to Enhancing the Development of the Child), the team (family and professionals) will identify major outcomes—changes the family and the other members of the team would like to see for the child and/or family. Major outcomes may range from broad, long-term goals to short-range objectives. Major outcomes should be written in commonly understood language. An outcome should be written so that it could be used to determine whether the goal/objective was met. A separate page is to be used for each major outcome.

Enter:

Major Outcome # The outcomes are numbered in the box for reference purposes only.

Major Outcome—for example

Johnny will eat table foods at family meals.

Ricky will learn to cruise in order to develop independent walking.

Mary will locate food placed in front of her in order to learn to feed herself.

Susan will find a child care center in order to provide adequate supervision of children enabling her to maintain a full-time job.

David will smile and make vocalizations during play and care giving to show that he is happy, pleased, satisfied.

Timeline (Target Date)—the date by which the team hopes this outcome will be reached. This is usually one year but may be less than one year but no more.

Action Steps

List the steps, activities, strategies needed to achieve outcomes, for example:

--have feeding assessment

--refer to and participate in feeding therapy if recommended by feeding assessment

--Susan will obtain a list of possible child care centers from friends and DHS

--home base interventionist will provide information to family on feeding strategies

Enter the name of the person(s) and agency responsible for each step, activity, or strategy.

Review/Changes

Review Status and **Date** are to be completed when reviews are completed and/or modification to the outcome is made with agreement by the family (and documented with a Review/Change form.)

Enter in the box beside review status the number which specifies the current status of the outcome.

If a modification is made the outcome, enter the modification to the outcome or steps on the Review/Change Form.

Comment is a brief statement or modification relating to the major outcome.

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OUTCOME/ACTION STEPS

Major Outcome # _____

Child's Name _____

Timeline (Target Date) _____

Outcome #(s)--the reference number for the major outcomes.

Provider name--the agency or person recommended to provide the service.

Required or Non-required--enter an "R" if the service is required by Part C or an "N" if the service is not required by Part C--see listing of required services on Page Eight (Outcome/Service Summary Page.)

Starting Date--the date on which the service is scheduled to begin.

Expected Duration--approximate length of time (weeks/months or actual date) that the service is expected to last.

Environment--in which the service is to be provided.

Frequency--the number of sessions scheduled each week or month, whichever is most appropriate. Do not use "TBD" or "to be determined."

Intensity--the length of time a service is provided during each session and whether it is provided on a group or individual basis.

Payor--by whom or how the provider will be compensated. Part C funds should be used only as a "last resort" after all other resources have been accessed.

Review Date and Review Status--columns are to be filled in when reviews are completed and/or modifications to the services are agreed upon (and documented with a Review/Change Form.) Add the service(s) from the Review/Change Form to this page.

Enter

Review date--the date on which the review took place.

Review status--use the status key at the bottom of the page and enter the appropriate number.

JUSTIFICATION FOR PROVISION OF SERVICE IN ENVIRONMENT/SETTING NOT IDENTIFIED AS THE NATURAL ENVIRONMENT

If any of the above environments are not listed on Page One as natural for this child/family, complete this section.

Service--the required service listed above that is not being provided in the natural environment.

Options Considered--the environments/settings that were identified by the family and team as natural environments/settings and were considered by the team as possible environments for service delivery.

Complete the statement "**The desired outcome could not be achieved in the natural environment because:**" This will be the justification for the services not provided in the natural environment.

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SERVICES

Child's Name _____

Service	Outcome #/s	Provider	Required or Non/Req	Starting Date	Expected Duration	Environment	METHOD			Payor	Review Date	*Review Status
							Frequency	Intensity				

Justification for Provision of Service in Environments/Settings not Identified as the Natural Environment

Service: _____ Options Considered _____

The desired outcome could not be achieved in the natural environment because: _____

Service: _____ Options Considered _____

The desired outcome could not be achieved in the natural environment because: _____

Service: _____ Options Considered _____

The desired outcome could not be achieved in the natural environment because: _____

***Review Status Key (1) on going (2) completed (3) delayed (4) unavailable (or nonrequired services only) (5) modified**

Page Eight: OUTCOMES/SERVICES SUMMARY PAGE

In the left hand column of this page, list the **Major Outcomes** (by number and description) from Page(s) Six. Across the row, identify those **Services to be Provided (required by Part C)** to the child entering a "C", those services to be provided to the family by entering an "F", and those services which will provided to child and family by entering "CF." Services which are required to be provided by Part C when needed are listed.

List other **Non-Required Services** which have been identified as beneficial to the child and/or family in the spaces provided.

<input type="checkbox"/>																				
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Page Nine: REVIEW/CHANGE FORM

This is a multipurpose page. It is used to enter

1. Changes/additions to identifying information entered on Page Two.
2. Information if there is a change in the child status.
3. Information regarding an IFSP review/change.

Enter **Child's Name**.

Enter **Date of Current IFSP**.

Enter **Review Date**—the date this form was completed. Also enter the review date on the Cover Page.

Enter a check under **Review Type** to indicate reason form is used.

Enter a check under **Review Status** to indicate the status of the IFSP.

Complete the box regarding **Inactive Status** if form is being completed to reflect inactive status (otherwise, do not complete.)

Enter the date when inactive status began. Circle one of the listed reasons for inactive status or specify "other" by giving a written description.

Enter reference of page/outcome#/service where changes/additions have been made.

Complete information regarding changes in outcomes or services as they occur.

Complete information regarding progress of outcomes at six month reviews or sooner if outcomes are completed.

This space may also be used to enter any changes to identifying information recorded on Page Two such as address, phone, parent.

Parent(s) check the appropriate boxes indicating their participation and approval and consent to the changes in the IFSP. Signatures of parent(s) and designated service coordinator are required.

Other IFSP Team Members Contributing to Review

Enter

Name (signature, if present, or printed, if not present, at time of review)

Title/Agency

Date contributed

Method of contribution (phone call, conference call, written review)

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REVIEW/CHANGE FORM

Child's Name _____
 Date of Current IFSP _____

Inactive Status _____ Date inactive status began _____

no longer eligible
 transition (Part B/Other) _____
 parent declined further service
 whereabouts unknown
 other (specify) _____

Review Date Status	Review Type	Review
IFSP _____	_____ six month	_____ continue
IFSP	_____ parent request	_____ change
IFSP	_____ provider request	_____ inactive

Enter reference of page/outcome#/service where changes/additions have been made.

yes **no**
 I have participated in the review of this IFSP.
 I approve the review status indicated and consent to the changes of outcome(s) and/or service(s) as in the IFSP.

noted

Parent _____ **Date** _____

Parent _____ **Date** _____

Other IFSP Team Member Contributing to Review

Name	Title/Agency	Date	Method

Designated Service Coordinator **Date**

Pages Ten and Eleven: TRANSITION FROM PART C SERVICES PLAN

Enter

Today's date—the date that the transition plan is being developed.

Child's Name

Date of Birth

Complete the **Name of the Current Program** and **Type** (home-based, child care, DMR center, physical therapy, etc.)

Anticipated Date of Transition—the child's third birthday.

Planned Transitioning Procedures are those steps needed to insure smooth transition from Part C services to Part B or other services as appropriate.

Implementor is the name and agency of person(s) responsible for each of the steps listed. The **Timeframe** is the projected date the step is to be completed. The **Date Completed** is the actual date the step was accomplished.

This form will be copied and transferred to subsequent IFSP's.

TRANSITION FROM PART C SERVICES PLAN

Today's Date _____
m/d/y

Child's Name _____

Date of Birth _____

Current Program _____
Name Type

Anticipated Date of Transition: _____

Planned Transitioning Procedures	Implementor	Timeframe	Date Completed

Transition Plan (cont.)

Child's Name _____

Transition Page # ____

Planned Transitioning Procedures	Implementor	Timeframe	Date Completed

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LEA _____

**PLANNING CONFERENCE
TRANSITION FROM PART C SERVICES**

Child's Name: _____	Date of Conference: _____
Child's Address: _____	_____ m/d/y
City: _____ State: ____ Zip: _____	(No later than 90 days, and up to 6 months, prior to the child's third birthday)
Child's Birthdate: _____	
Child's Phone Number: _____	Note: Attach additional pages for notes or signatures, as needed
Parent's Name: _____	

Conference Notes: List/summarize activities discussed and/or planned to facilitate a smooth transition for this child and family from Part C Services

Conference Participants: (Signature)

Parent/s participation: (Signature) _____ _____	Date _____ Date _____	<input type="checkbox"/> I have participated in the decisions made during this Transition Conference. <input type="checkbox"/> I agree disagree with the decisions made at this meeting . <input type="checkbox"/> I have been informed of my Rights as a parent of a child with disability under Part B of IDEA.	
Other Participants/Name	Title	Agency/LEA	Date
	Designated Service Coordinator		
	LEA Representative		
	TEIS Representative		
	Other Agency Representatives		

6/22/98 Please fax a copy of this completed document to the State Department of Education at (615)532-9412 following this Planning Conference.

Planning Conference Transition From Part C Services Instructions

Required or Equivalent Form

Purpose: To document discussion and plans made at the transition meeting held 6 months to 90 days prior to the Part C eligible child's third birthday. CFR 303.148 (b) (2) ; CFR 303.344 (h)

Method: The designated service coordinator completes this form during the transition meeting or shortly afterwards. It is faxed to the Department of Education, Division of Special Education, Office of Early Childhood, where it is filed for monitoring purposes.

Directions:

1. Complete the identifying information regarding the child and family.
2. Complete the date the transition conference was held (90 days to 6 months prior to the third birthday.)
3. Summarize the discussion and plans made during the transition meeting. The complete transition plan is included in the IFSP.
4. Document the parent's participation in the meeting and their agreement to the plans. Document that parents have received a copy of parental rights under Part B.
5. Document the other participants attendance at the transition meeting by signatures. At a minimum the participants consists of the parents, designated service coordinator, TEIS representative, who may also be the designated service coordinator and LEA representative.

6. Fax this form to the Department of Education following the conference.