

Idaho Infant Toddler Program  
**Individualized Family Service Plan - Part 1**  
**Assessment and Planning Tool**

*The mission of the Idaho Infant Toddler Program is to provide quality early intervention support and services to enhance the capacity of families to meet the needs of children birth to three years of age who have developmental delays or disabilities.*

*We would like to begin by gathering some information about your child and family. This information will be shared with your team and will help in making decisions about eligibility and recommendations for possible services.*

*If your child is found eligible, this information will be used to develop the Individualized Family Service Plan (IFSP). This information also serves as the Service Coordination Assessment.*

<b>Demographic Information</b>			
Child's Name: _____		Date of Birth: _____	<input type="checkbox"/> Female <input type="checkbox"/> Male
Parent/Guardian: _____		Relationship: _____	
Address: _____		City: _____	State: _____ Zip: _____
Phone Number: _____		(w) <input type="checkbox"/> (h) <input type="checkbox"/> (c) <input type="checkbox"/>	E-mail Address: _____
Phone Number: _____		(w) <input type="checkbox"/> (h) <input type="checkbox"/> (c) <input type="checkbox"/>	_____ (w) <input type="checkbox"/> (h) <input type="checkbox"/> (c) <input type="checkbox"/>
2 <sup>nd</sup> Contact: _____		Relationship: _____	
Address: _____		City: _____	State: _____ Zip: _____
Phone Number: _____		(w) <input type="checkbox"/> (h) <input type="checkbox"/> (c) <input type="checkbox"/>	E-mail Address: _____
Family's Primary Language: _____			
<b>Health Information</b>			
Primary Care Physician: _____		Medicaid #: _____	
Clinic Name: _____			
Address: _____		City: _____	State: _____ Zip: _____
Phone Number: _____		FAX: _____	Email Address: _____
Healthy Connections? Y <input type="checkbox"/> N <input type="checkbox"/>		Insurance Company: _____	Policy #: _____
<b>Service Coordination Information</b>			
Service Coordinator: _____		Agency: _____	
Agency Address: _____		City: _____	State: _____ Zip: _____
Phone Number: _____		Email Address: _____	
<input type="checkbox"/> Intake Only	<input type="checkbox"/> Initial IFSP	<input type="checkbox"/> Annual IFSP	Date of Original IFSP: _____

## Family Information

Please describe the concerns that brought you to the Infant Toddler Program:

Have you discussed this concern with your child's doctor or other professionals? Please explain.

What do you hope to see happen for your child and/or family as a result of your involvement with the Infant Toddler Program?

Child lives with:

Other Caregivers:

Foster Care

Child typically spends the day with:

Siblings / age:

Pets:

Other important people:

Additional important information:

Does child use or need any assistive technology like hearing aids, orthotics, or positioning supports?

### HEALTH HISTORY

Medical Records/ Information Available:

Medical records

Medical/Social Report

Current Annual History and Physical Exam Date:

Dental, Hearing or Vision Providers:

Medications (name, dosage, frequency):

Other:

Please describe your child's prenatal and birth history, birth weight/length, medical conditions, illnesses, injuries, hospitalizations, immunizations, allergies, sleep patterns, etc. Is there a family history of physical or mental illness, disability, vision or hearing loss?

<b>CHILD/FAMILY ROUTINES &amp; ACTIVITIES</b>	<i>Related Resources:</i> <input type="checkbox"/> <i>Interest-Based Everyday Activity Checklist</i> <input type="checkbox"/> <i>ABC Matrix</i> <input type="checkbox"/> <i>RBI-SAFER Combo</i> <input type="checkbox"/> <i>Other:</i> _____
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**What are the things your child enjoys most (including toys, people, places, activities, etc) or does very well?**

**What does your family enjoy doing together and why? Who is involved? When does this occur?**

**What activities/routines do you do throughout the day? How does your child participate? How satisfied with the activities/routines are you?**

**Are there any routines or activities that you find difficult or frustrating for you or your child? Or are there activities/routines that your family is not currently involved in because of your child's needs, but you are interested in doing now or in the near future?**

**Have you or your child participated in any of the following programs?**

Past	Present	Department of Health and Welfare	Past	Present	Health Services	Past	Present	Other
<input type="checkbox"/>	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	<input type="checkbox"/>	WIC Nutrition Program	<input type="checkbox"/>	<input type="checkbox"/>	Early Head Start/Head Start
<input type="checkbox"/>	<input type="checkbox"/>	Food Stamps	<input type="checkbox"/>	<input type="checkbox"/>	High Risk Infant or Maternal Care	<input type="checkbox"/>	<input type="checkbox"/>	Idaho Migrant Head Start
<input type="checkbox"/>	<input type="checkbox"/>	Financial Assistance	<input type="checkbox"/>	<input type="checkbox"/>	Immunizations (Baby Shots)	<input type="checkbox"/>	<input type="checkbox"/>	Indian Health Services
<input type="checkbox"/>	<input type="checkbox"/>	Home Care for Certain Disabled Children (Katie Beckett)	<input type="checkbox"/>	<input type="checkbox"/>	Family Planning Clinic	<input type="checkbox"/>	<input type="checkbox"/>	EPSDT Well Child Check
			<input type="checkbox"/>	<input type="checkbox"/>	Maternity Clinic	<input type="checkbox"/>	<input type="checkbox"/>	Social Security
<input type="checkbox"/>	<input type="checkbox"/>	Child Protection	<input type="checkbox"/>	<input type="checkbox"/>	Children's Special Health Program	<input type="checkbox"/>	<input type="checkbox"/>	IESDB
<input type="checkbox"/>	<input type="checkbox"/>	Personal Care Services	<input type="checkbox"/>	<input type="checkbox"/>	Ages and Stages Questionnaires			
<input type="checkbox"/>	<input type="checkbox"/>	Adult or Children's Mental Health						
<input type="checkbox"/>	<input type="checkbox"/>	Family Supports						

**Comments:**

<b>RESOURCE DEVELOPMENT</b>	<i>Related Resources:</i> <input type="checkbox"/> <i>Ecological Family Mapping (ECO Map)</i>
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*Your family's strengths and resources can support your child's learning. To best serve your child, it is helpful to know about issues or concerns that are important to you. You may share as much or as little family information as you choose.*

**What types of resources and supports can your family count on?**

**Do you have concerns about meeting the needs of your child or family? Please check any items below that apply.**

Concern	Immediate Concern		Concern	Immediate Concern	
<input type="checkbox"/>	<input type="checkbox"/>	Physical (food, shelter, transportation, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	Therapy (adaptive equipment, assessments, scheduling)
<input type="checkbox"/>	<input type="checkbox"/>	Medical (vision, hearing, dental, immunizations and physical health)	<input type="checkbox"/>	<input type="checkbox"/>	Personal (recreation, stress management, respite, legal, etc.)
<input type="checkbox"/>	<input type="checkbox"/>	Health & Safety (nutrition, feeding, environmental, Child or Adult Protection, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	Long Range planning (changes that will occur, transitions, continued service coordination, etc.)
<input type="checkbox"/>	<input type="checkbox"/>	Educational (parenting/discipline, child development, developmental disabilities, parent rights/safeguards, transitions, English as a second language, obtaining GED, Vo-Tech, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	Financial/Benefits (income, bills, Medicaid, SSI, Katie Beckett, etc.)
			<input type="checkbox"/>	<input type="checkbox"/>	Translation/Interpretation services
<input type="checkbox"/>	<input type="checkbox"/>	Social & Emotional (support groups, playgroups, nurturing, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	Other:
<input type="checkbox"/>	<input type="checkbox"/>	Family needs and supports (how to communicate about child's disability, recreation, respite, counseling, etc.)			

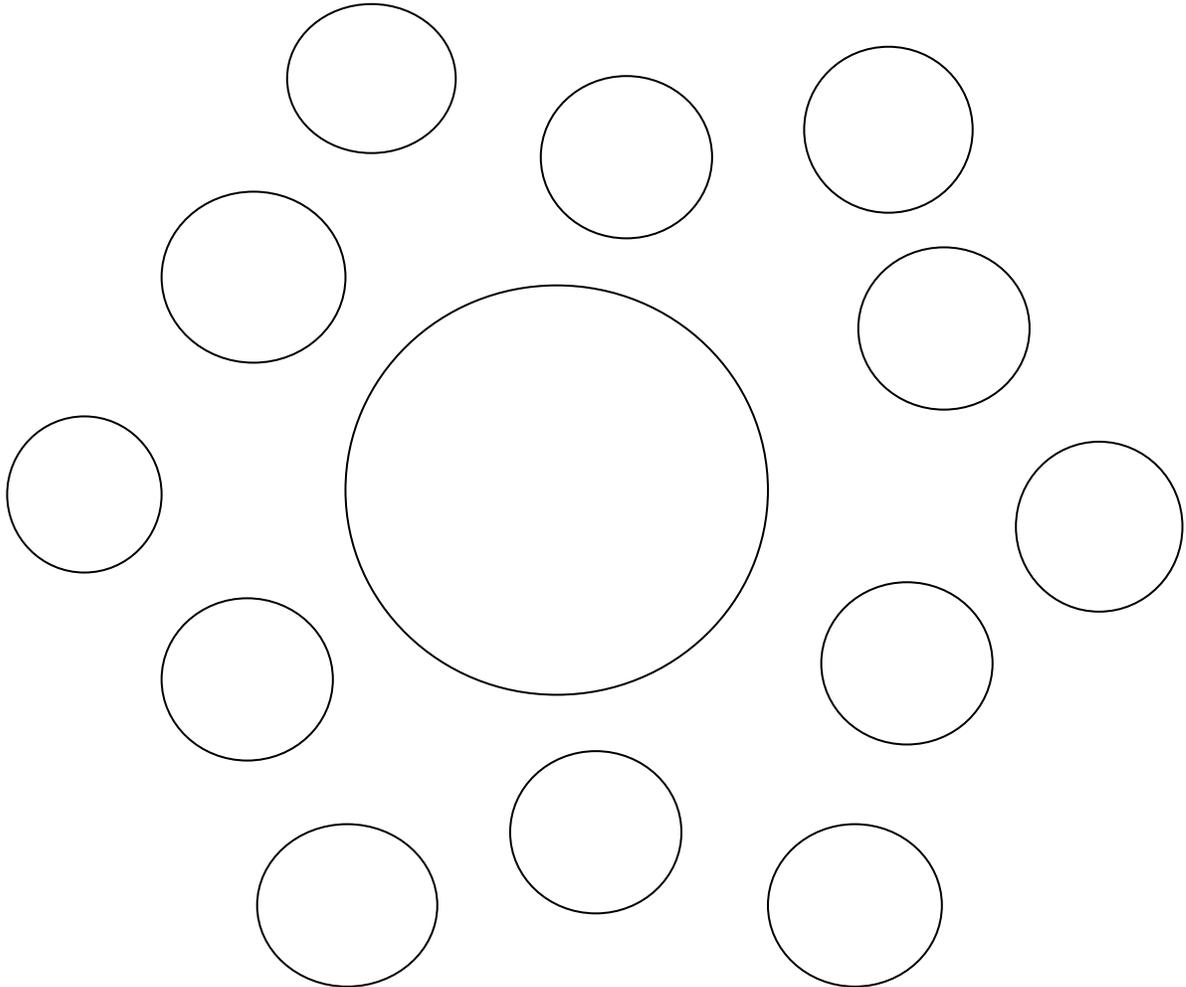
**Please describe items checked above. Describe other resources about which you'd like more information:**

**Social Information – Psychosocial Stressors/Events** (check all that apply within the past year)

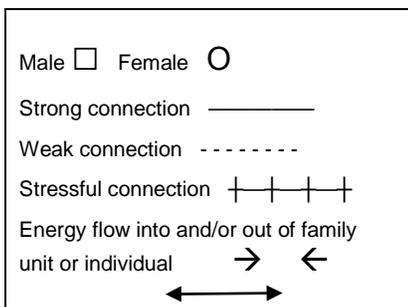
<input type="checkbox"/> Recent Death	<input type="checkbox"/> Financial Difficulties	<input type="checkbox"/> None
<input type="checkbox"/> Physical/Sexual/Emotional Abuse	<input type="checkbox"/> Parent Separation/Divorce	<input type="checkbox"/> Would you like information on possible resources related to any items you've identified?
<input type="checkbox"/> Recent Hospitalization	<input type="checkbox"/> Change in Living Situation	
<input type="checkbox"/> Custody/Placement Issues	<input type="checkbox"/> Other (please describe):	
<input type="checkbox"/> Child or Family Legal Issues		

## Ecological Mapping

1. Each member can be represented by a color that they have chosen.
2. Document relationships and supports.
3. Activities that the family does together can be depicted by another color that will extend from the center of the circle to the activity outside the circle.  
(Please see supplemental document for instructions and examples)



Lines joining the circles show connections:



# Description of Child

Present Level of Development (Information required for each domain)		
Area of Development	Parent/Caregiver Input	Other Data Sources (Observation, Evaluation Results, Medical Records, etc.)
<b>Cognitive -</b> Thinking and learning <i>(ex., look for dropped toy; pull toy on a string; do a simple puzzle).</i>		
<b>Communication -</b> Expressive/Receptive <i>(ex., startle at loud noises; makes sounds; understands sounds, words, gestures and talking; uses two or more word sentences; points to desired objects).</i>		
<b>Physical -</b> Gross & Fine Motor/Sensory <i>(ex., reach for and play with toys; sit, roll, crawl; throw a small ball; thread cord through large beads).</i>		
<b>Social/Emotional -</b> Interacting with others <i>(ex., smile and coo; pull on your hand or clothes to gain attention; share a toy; take turns with others).</i>		
<b>Adaptive -</b> Feeding, eating, dressing, and sleeping <i>(ex., help hold a bottle; reach for a toy; help dress himself or herself).</i>		

Vision/Hearing Screenings (Check all that apply)	
<p><b><u>Vision</u></b></p> <p>Concern Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>Screening Requested <input type="checkbox"/></p> <p>Screening Results: <input type="checkbox"/> Passed <input type="checkbox"/> Referred</p> <p>Date of Screening: _____</p> <p>Screening Completed By: _____</p> <p>Follow Up Needed: _____</p>	<p><b><u>Hearing</u></b></p> <p>Concern Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>Newborn or Other Screening Requested <input type="checkbox"/></p> <p>Newborn or Other Screening Results: <input type="checkbox"/> Passed <input type="checkbox"/> Referred</p> <p>Date of Screening: _____</p> <p>Screening Completed By: _____</p> <p>Follow Up Needed: _____</p>

# Idaho Infant Toddler Program Individualized Family Service Plan - Part 2 Plan Development

*The development of an Individualized Family Service Plan (IFSP) is a process in which family members and service providers work together as partners. Together we will create a plan of action to support your family in meeting your child's developmental needs.*



*Specialists from a variety of backgrounds and qualifications are available to work with and support your family in promoting your child's development and learning. The following people are members of your early intervention team.*

Name	Role	Agency/Address	Phone	Email
	Parent			
	Service Coordinator			

EARLY INTERVENTION TEAM PHOTOS (OPTIONAL)

Initial IFSP     
  Annual IFSP     
  6 Month Review     
 Date of Original IFSP: \_\_\_\_\_





# Outcomes for Service Coordination

Service Coordination is provided to all families enrolled in the Idaho Infant Toddler Program. A Service Coordinator will help your child and family access resources and supports. This page will outline steps and activities to assist you and your child as you move through the early intervention system.

<b>Outcome #1</b>	<b>What do we want to accomplish?</b> (Desired Outcome)	Start Date:
		Target Date:
<b>Who will do what?</b> (Strategies/Activities)		Review Date: Progress Code: Comments:

<b>Outcome #:</b>	<b>What do we want to accomplish?</b> (Desired Outcome)	Start Date:
		Target Date:
<b>Who will do what?</b> (Strategies/Activities)		Review Date: Progress Code: Comments:

<b>Outcome #:</b>	<b>What do we want to accomplish?</b> (Desired Outcome)	Start Date:
		Target Date:
<b>Who will do what?</b> (Strategies/Activities)		Review Date: Progress Code: Comments:

**This box outlines what steps the family can take in an emergency.**

<b>Emergency Contact Plan:</b>	Review Date: Progress Code: Comments:
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**Progress Review Codes:**      **N = New**      **C = Continue**      **A = Achieved**      **R = Revised**      **D = Discontinued**

<input type="checkbox"/> Updated Outcome / Date: _____ *Parent Initials: _____ *Parent's Initials indicate agreement with the changes noted on this page.	<input type="checkbox"/> Addendum / Date: _____
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# Transition Planning

*This page describes transition activities that you and your family can participate in over the next several months. Transitions are big changes that occur in your family's life. Things like: bringing your child from the hospital to home, changing a child care provider, or going to preschool. Please help us develop a plan to explore options you are interested in for your child after age three and to meet your child's and families transition-related needs.*

<b>Transition Steps/Services Identified by Family</b> (Includes discussions with, and training of parents, as appropriate, regarding the future placement and steps to prepare a child for changes in services and settings and any necessary transition services for a child and his/her family)	<b>Who is Responsible?</b>	<b>Proj. Start Date</b>	<b>Review Date/Code</b>

**Progress Review Codes:**      **N = New**      **C = Continue**      **A = Achieved**      **R = Revised**      **D = Discontinued**

## Transition Steps For Children Who May Be Eligible For School District Services

(Include steps to be taken and who will do what)

Notify school district of potentially eligible child	Proj. Start Date:	Date Completed:
Schedule and hold transition conference (between 9 months and 90 days before child's 3 <sup>rd</sup> birthday)	Proj. Start Date:	Date Completed:
Complete evaluations as determined at transition conference	Proj. Start Date:	Date Completed:
Schedule family visits at school and/or community settings, as determined during transition planning	Proj. Start Date:	Date Completed:
Post Transitional Activities including completion of Early Childhood Outcomes	Proj. Start Date:	Date Completed:
Other	Proj. Start Date:	Date Completed:

**School District #** \_\_\_\_\_ **Contact Information:** \_\_\_\_\_

## Summary of Services

Early Intervention Services	Person(s)/Agency(ies) Responsible	Start Date End Date (Duration)	Length (time service provided) Frequency (# of days or sessions) Intensity (individual/group) Method (how service provided) Location (place of service)	Funding Source If Medicaid, MID #	*NE	
					Y	N
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
<b>Other services the child or family needs or is receiving through other sources that are not required or funded by the Infant Toddler Program (Part C of IDEA)</b>						
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
*NE: If No, please complete the Natural Environment Justification page.						
<b>Diagnosis Description:</b>						
<b>Condition Code:</b>			<b>ICD-9 Code:</b>			

### Consent by Parents/Guardians for Provision of Services

I participated in the development of this plan. I understand that:

- With receipt of my Procedural Safeguards, this plan serves as Prior Written Notice for evaluation, placement, and/or the provision of listed services.
- If there is an increase in the frequency or intensity of services, I will be provided with a copy of the Infant Toddler Program's System of Payment Policy.
- The provision of listed services includes the completion of ongoing assessments.

I give informed consent for this Individualized Family Service Plan (IFSP) to be carried out as written.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Physician Signature and Financial Authorization

I have reviewed the above health-related services and certify that they are medically necessary.

\*Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(\*Required for Medicaid reimbursement if other MD order not on file)

I have reviewed and authorize payment for the above listed early intervention services as defined in the Individuals with Disabilities Education Act (IDEA) Reauthorization, Public Law 108-446, Part C.

Lead Agency Authorizing Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Date of IFSP: \_\_\_\_\_

Addendum / Date: \_\_\_\_\_

6 Month review: \_\_\_\_\_

Initial  Annual

Reason for Addendum: \_\_\_\_\_

## Justification for Services Outside a Natural Environment

*Supports and services must be provided in settings that are natural or typical for children of the same age. If, as a team, we decide an outcome cannot be achieved in a natural environment, we need to describe why we made that decision and what we will do to move services and supports into natural environments as soon as possible.*

Early Intervention Services	Outcome #	Setting (Setting where service(s)/support(s) will be provided)
<b>Explanation of Why Outcome Cannot be Achieved in a Natural Environment:</b>		
<b>Plan and Timeline for Moving Service(s) and/or Support(s) into Natural Environments:</b>		
Projected Review Date: _____		

<b>Date of Review:</b>
<b>IFSP Team Participants (including Parents/Caregiver):</b>
<b>Recommendations:</b>