

Idaho Infant Toddler Program Individualized Family Service Plan

Created on _____
(Today's Date)

For the family of _____
(Child's Name)

Who was born on _____
(Date of Birth)

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Dear Family,

The development of an Individualized Family Service Plan 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.

You know your child better than any professional. You are an essential member of the team. Please speak freely to help us understand what will be useful to you and your child. Service providers will give you information about services available. You can then decide what services will best address your concerns. We are committed to making this planning process comfortable and valuable to you, your child, and other team members. This plan will be reviewed every six months, or more frequently upon request, to respond to your child's and family's changing needs. We look forward to developing a meaningful relationship with you and hope you will share your ideas and suggestions on how this process can be improved.

Children learn best in familiar places where they are comfortable. The Infant Toddler Program provides services in these places, which are called the child's "natural learning environments".

To help determine your child's natural learning environments, please consider your family's typical activities and routines. Think about where your child (and / or other children) spends time. Are there places you would like him or her to spend more time? Are some of these places possible sites for early intervention activities?

Your child's learning can hinge upon your family's strengths, needs and resources. To best serve your child, it is helpful to know about issues or concerns that are important to your family.

You may share as much or as little family information as you choose. The following categories may guide your thinking as you respond to the questions in the box.

Physical (food, shelter, transportation, etc.)

Financial (income, bills, etc.)

Health (medical, safety, immunizations, etc.)

Guidance (discipline, parenting, etc.)

Emotional (nurturing, love, companionship, etc.)

Recreation (free time, activities, sports, etc.)

Priorities for

_____ 's Family

(Child's Name)

What are your child's daily routines and activities? Where do they take place? Who usually spends time with him or her? (Natural Learning Environments)

(Sharing the following family information is voluntary.)

What people, places and things are (or could be) supportive and helpful to your family and child? (Resources)

What things are most important, or of most concern to you and your family?

Summary of Early Intervention Services

Child's Name _____ Birth Date _____ SS# _____ Date of IFSP _____
 Parent's Name(s) _____ Review Due _____
(6 month / Annual / Other)
 Address _____ City _____ Phone _____
 Insurance Co. _____ Policy # _____ Eligibility/Diagnosis Code(s) _____
 Medicaid # _____ Healthy Connections? Yes No
 Service Coordinator _____ Agency _____ Phone _____

Early Intervention Services	Outcome (Key Word or Number)	Method, Frequency, and Duration of Service	* Payment Source	Person(s) / Agency(ies) Responsible

Parental Consent for Services

I (We) understand and have participated in the development of this plan. I (We) give consent to implement the services outlined above.

 (Parent Signature) _____ (Date)

 (Parent Signature) _____ (Date)

When the parent is in attendance and has received a copy of Parent's Rights, this plan serves as prior written notice for evaluation, placement and/or the provision of listed services.

Physician Signature

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

 Physician Signature (* Required for Medicaid reimbursement) _____ (Date)

*Financial Authorization

I have reviewed and authorize payment for the above listed Early Intervention Services as defined in the *Individuals with Disabilities Education Act*, (IDEA) Public Law 105-17, Part C.

 Lead Agency Authorizing Signature _____ (Date)

Team Members

_____ 's plan was developed by the following people:
 (Child's Name)

Name / Signature	Role	Address	Phone
	Parent		
	Service Coordinator		

Others who may be helpful to the IFSP team: (If Primary Health Care Provider is not listed above, please include below)

Name	Role	Address	Phone

