

Child's Name:

DOB:

IFSP Start Date:

# 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:			Female	Male
Parent/Guardian:	Relationship:				
Address:	City:		State:	Zip:	
Phone Number:	(w)	(h)	(c)	Email Address:	
Phone Number:	(w)	(h)	(c)	(w)	(h) (c)
2 <sup>nd</sup> Contact:	Relationship:				
Address:	City:		State:	Zip:	
Phone Number:	(w)	(h)	(c)	Email Address:	
Family's Primary Language:	Child's Race/Ethnicity:				
Additional Info (e.g. prefer text, directions):					
<b>Health Information</b>					
Primary Care Physician:	Medicaid #:				
Clinic Name:					
Address:	City:		State:	Zip:	
Phone Number:	FAX:		Email Address:		
Healthy Connections? Y	N	Insurance Company:		Policy #:	
<b>Service Coordination Information</b>					
Service Coordinator:	Agency:				
Agency Address:	City:		State:	Zip:	
Phone Number:	FAX :		Email Address:		
Intake Only	Initial IFSP	6 Month Review	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 within the next year 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:*

*Other Medical 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>SHoRE</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?**

**Are there times in which you find it difficult to soothe your child? What are you currently doing? Are you interested in learning more about ways to soothe yourself or your child? (Refer to the Outcomes for Service Coordination page for soothing strategies)**

**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
			Medicaid				WIC Nutrition Program				Early Head Start or Head Start
			Food Stamps				High Risk Infant or Maternal Care				Idaho Migrant Head Start
			Financial Assistance				Immunizations (Baby Shots)				Indian Health Services
			Home Care for Certain Disabled Children (Katie Beckett)				Family Planning Clinic				EPSDT Well Child Check
				Maternity Clinic				Social Security			
			Child Protection				Children's Special Health Program				IESDB
			Personal Care Services				Ages and Stages Questionnaires				Children's DD Services
			Adult or Children's Mental Health								
			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 within the next year?  
 If so, please check any items below that apply. Circle those that are of immediate concern:**

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

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

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

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

Child's Name: \_\_\_\_\_

DOB: \_\_\_\_\_

IFSP Start Date \_\_\_\_\_

## 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 those 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>

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## 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 you and your early intervention team work together as partners. Together we will create a plan of action based on your family and child's needs and assessments 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	Date of Original IFSP:
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Child's Name:

DOB:

IFSP Start Date:

# Outcomes for Child

Now that we have identified your child's interests and needs through the family and child assessments, we will focus on what you would like your child to do.

<b>Outcome #</b>	<b>What specifically do we want your child to do in the next few months? (Functional Outcome)</b>

<b>What is your child doing now?</b> (Child's current level of function related to this outcome.)

*The progress statement must be measured within the context of everyday learning activities.*

<b>How will we know we're making progress? What will be different?</b>
<b>When do we hope to have this completed?</b> (Progress Statement/Criteria for Success)

<b>What strategies and resources will we use to make this happen?</b>
(Who will do <i>what</i> during <i>which</i> regular activities and routines, and <i>where</i> will it occur?)

<b>Who will be involved?</b> (Include names of all who will be involved)

Review of Progress Statement/Criteria for Success			
Date:	6 Month	Annual	Progress
<b>What Contributed to Progress? Lack of Progress?</b>			<b>Achieved:</b> We did it! <b>Continue:</b> We are part way there. Let's keep going. <b>Discontinue:</b> It no longer applies. <b>Revise:</b> Let's try something different.
<b>Additional Comments:</b>			

New or Modified Outcome/Addendum Date:	*Parent Initials: _____
*Parent's initials indicate agreement with the changes noted on this page, but does not replace the signed Addendum SOS when required.	

Child's Name:

DOB:

IFSP Start Date:

# Outcomes for Parent/Caregiver

This page documents what you and your family would like to achieve in order to support your child's development.

<b>Outcome #</b>	<b>What specifically do we want to accomplish? (Functional Outcome)</b>

<b>What is happening now?</b>

<b>How will we know we're making progress? What will be different? When do we hope to have this completed? (Progress Statement/Criteria for Success)</b>

<b>What strategies and resources will we use to make this happen? (Who will do what during which regular activities and routines, and where will it occur?)</b>

<b>Who will be involved? (Include names and phone numbers)</b>

Review of Progress Statement/Criteria for Success			
Date:	6 Month	Annual	Progress
<b>What Contributed to Progress? Lack of Progress?</b>			
<b>Additional Comments:</b>			

Achieved: We did it!  
 Continue: We are part way there. Let's keep going.  
 Discontinue: It no longer applies.  
 Revise: Let's try something different.

New or Modified Outcome/Addendum Date:	*Parent Initials: _____
*Parent's initials indicate agreement with the changes noted on this page, but does not replace the signed Addendum SOS when required.	

Child's Name:

DOB:

IFSP Start Date:

# 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 and will work with you to establish your Individualized Family Service Plan. This page will outline steps and activities to assist you and your child as you move through the early intervention system.

Children and families participating in the program may encounter transitions at any point in time. Transitions are big changes that occur in your family's life. Service coordination outcomes should also describe transition activities that you and your family can participate in over the next several months. Things like: bringing your child from the hospital to home, starting or changing a child care provider, or moving to a new home.

<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:

<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>Strategies to soothe yourself and your child (optional):</b>	Start Date:  Comments:
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**Progress Review Codes:**      **N = New**      **C = Continue**      **A = Achieved**      **R= Revised**      **D = Discontinued**

New or Modified Outcome/Addendum Date: \_\_\_\_\_ \*Parent Initials: \_\_\_\_\_

*\*Parent's initials indicate agreement with the changes noted on this page, but does not replace the signed Addendum SOS when required.*

## Plan for Transition from the Infant Toddler Program

*The ITP must ensure a transition plan is established within a child's IFSP no fewer than 90 days, and at the discretion of all parties, not more than 9 months before a child turns three years of age. The transition plan must include steps for the child with a disability and their family to exit from ITP.*

As we think about your child's participation with the Infant Toddler Program ending at age three, your hopes and concerns are:

We are interested in learning more about and/or participating in community-based and other program options:

Play group	Library programs
Parks and recreation programs	Head Start
Child care	Private preschool
Medicaid Children's DD program	Transportation to programs
Therapy Services (Occupational, Physical, Speech-Language Pathology, etc.)	
Preschool special education through my local school district if my child is eligible	
Other community programs:	

### School District Transition Timeline Dates

Transition Activities:		Projected Start Date:	Date Completed:
Notify school district and State Educational Agency of potentially eligible child (no fewer than 90 days before child's 3 <sup>rd</sup> birthday, or as soon as possible if determined eligible for Part C services between 45 days and 90 days before child's 3 <sup>rd</sup> birthday)			
Schedule and hold transition conference (between 9 months and 90 days before child's 3 <sup>rd</sup> birthday)			
Provide transition documentation at transition conference (obtain parental consent)			
School District Name/School District #	Contact Name	Contact Phone Number	

### What will help prepare our family and child for what's next?

(visiting a program, parent training, assistance with applying for Medicaid DD services, transportation needs, assistive technology needs, etc.)

What actions or activities?	Who will help?	When?

Child's Name

DOB

IFSP Start Date

**Summary of Services**

Physician's Recommendation Only

Service Coordinator Signature:

Date:

Early Intervention Services & Intensity (individual/group)	Person(s)/ Agency(ies) Responsible	Start Date End Date (Duration)	Length (time service provided) Frequency (# of days or sessions) Method (how service provided) Location (place of service)	Funding Source If Medicaid, MID #	*NE Y or N

\*NE: If No, please complete the Natural Environment Justification page.

**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)**


**Diagnosis Description:****ICD-10 Code:****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, length, duration, or intensity of services, a copy of the Infant Toddler Program's System of Payment policy will be provided and reviewed with me.
- 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 Recommendation and Financial Authorization**

I have reviewed the above health-related services and certify that they are medically necessary and that continued care is necessary for the duration of services listed in this Individualized Family Service Plan.

\*Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Name (Printed or Typed): \_\_\_\_\_ Clinic: \_\_\_\_\_

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:  
6 Month review

Initial

Annual

Addendum / Date:  
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>
IFSP Team Participants (including Parents/Caregiver):
Recommendations: