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
					Yes
					Yes
					Yes
					Yes
					Yes

***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