# 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.

Demographic Information			
Child's Name:	_ Date of Birth:	□ Female □ <i>M</i>	ale
Parent/Guardian:	Relationship:		
Address:	City:	State:	_ Zip:
Phone Number:(	v) 🗆 (h) 🗆 (c) 🗆 🛮 E-mail A	ddress:	
Additional Phone Numbers:	(w) 🗆 (h) 🗆 (c) 🗆 🗀 :	(w	() = (h) = (c) =
2 <sup>nd</sup> Contact:	Relationship:		
Address:	City:	State:	Zip:
Phone Number:(	v) 🗆 (h) 🗆 (c) 🗆 🛮 E-mail A	ddress:	
Family Primary Language:			
Health Information			
Primary Care Physician:	Medi	caid #:	
Address:	City:	State:	Zip:
Phone Number:	Emai	l Address:	
Healthy Connections? Y N Insurance Comp	any:	Policy #: _	
Service Coordination Information			
Service Coordinator:	Agency:		_
Agency Address:	City:	State:	Zip:
Phone Number:	Email Address:		

Child's Name: \_

Date Completed:

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# **Family Information**

Please describe the concerns that brought you to the	e 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/o	or family as a result of your involvement with the Infant			
Child lives with:	Relationship:			
Other Caregivers:	☐ Foster Care			
Child typically spends the day with:				
Siblings / age:				
Pets:				
Other important people:				
Additional important information:				
HEALTH HISTORY	Additional Information Available:  □ Medical records □ Medical/Social Report Attached In Perm File □ Other:			
Please describe your child's prenatal and birth history, m immunizations, allergies, sleep patterns, etc. Is there a t hearing loss?	nedical conditions, illnesses, injuries, hospitalizations, family history of physical or mental illness, disability, vision or			

Child's Name:

Date Completed:

Idaho Infant Toddler Program

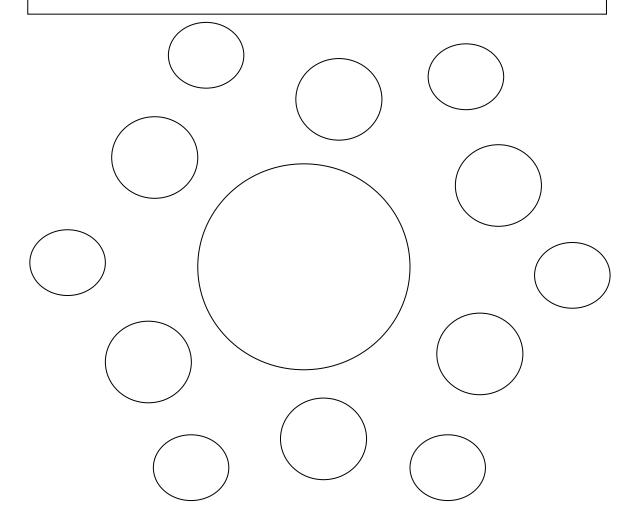
CHILD/FAMILY ROUTINES & ACTIVITIES			Related Resources:  □ Interest-Based Everyday Activity Checklist □ ABC Matrix						
What are the things your child enjoys most (including toys, people, places, activities, etc)?									
W	nat	are the things your child enjoys m	os	t (i	ncluding	y toys, people, places, ac	tivit	ies,	etc)?
W	hat	does your family enjoy doing toge	the	er a	and why	? Who is involved? Whe	en d	oes	this occur?
					-				
Ar	e t	here any routines or activities that	yo	u fi	ind diffic	cult or frustrating for you	or y	oui	child?
_				_					
		here activities/routines that your fa				irrently involved in becau	ise (	ot y	our child's needs, but you
ar	e II	nterested in doing now or in the ne	ar i	uti	ure?				
Ha		you or your child participated in a	ny			wing programs?			
st	Present	Department of Health and Welfare	St	Present		Health Services	st	Present	<u>Other</u>
Past	Pre	Madianid	Past	Pre		deities December	Past	Pre	Farth Hand Otart and Hand Otart
		Medicaid Food Stamps				utrition Program sk Infant or Maternal Care	-		Early Head Start or Head Start Idaho Migrant Head Start
		Financial Assistance				zations (Baby Shots)	-		Indian Health Services
		Home Care for Certain Disabled				Planning Clinic			EPSDT Well Chilld Check
		Children (Katie Beckett)				ty Clinic			Social Security
		Child Protection			Childre	n's Special Health Program			IESDB
		Personal Care Services				nd Stages Questionnaires			
		Intensive Behavioral Intervention							
		Adult or Children's Mental Health							
		Family Supports							
C-	mr	nents:		<u> </u>					
	ווווונ	ienis.							
lda	ho l	nfant Toddler Program				Child's Name	e:		

Date Completed:

DECOURCE DEVELOPMENT	Related Resources:				
RESOURCE DEVELOPMENT   □ Ecological Family Mapping (ECO Map)					
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 you	-				
If so, please check any items below that apply. Circle the					
□ Physical (food, shelter, transportation, etc.)	<ul> <li>Educational (parenting/discipline, child development, developmental disabilities, parent rights/safeguards,</li> </ul>				
<ul> <li>Medical (vision, hearing, dental, immunizations and physical health)</li> </ul>	transitions, English as a second language, obtaining GED, Vo-Tech, etc.)				
<ul> <li>Health &amp; Safety (nutrition, feeding, environmental, Child or Adult Protection, etc.)</li> </ul>	<ul> <li>Personal (recreation, stress management, respite, legal, etc.)</li> </ul>				
☐ Therapy (adaptive equipment, assessments, scheduling)	<ul> <li>Long Range planning (changes that will occur, transitions, continued service coordination, etc.)</li> </ul>				
□ Social & Emotional (support groups, playgroups, nurturing, etc.)	<ul> <li>Financial/Benefits (income, bills, Medicaid, SSI, Katie Beckett, etc.)</li> </ul>				
<ul> <li>Family needs and supports (how to communicate about child's disability, recreation, respite, counseling, etc.)</li> </ul>	<ul><li>□ Translation / Interpretation services</li><li>□ Other</li></ul>				
Please describe items checked above:					
-					
Are there other resources about which you'd like more	information?				
Additional Notes:					
Idaho Infant Toddler Program	Child's Name:				
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#### **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:

Male ☐ Female O
Strong connection ———
Weak connection
Stressful connection +++++
Energy flow into and/or out of family unit or individual

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

Date Completed: \_\_\_\_\_\_

## **Description of Child**

Present Level of Development					
Area of Development	Parent/Car	egiver Input	Other Data Sources (Observation, Evaluation Results, Medical Records, etc.)		
Cognitive - Thinking and learning (ex., look for dropped toy; pull toy on a string; do a simple puzzle).					
Communication - Expressive/Receptive (ex., startle at loud noises; makes sounds; understands sounds, words, gestures and talking; uses two or more word sentences; points to desired objects).					
Physical - Gross & Fine Motor/Sensory (ex., reach for and play with toes; sit, roll, crawl; throw a small ball; thread cord through large beads).					
Social/Emotional - Interacting with others (ex., smile and coo; pull on your hand or clothes to gain attention; share a toy; take turns with others).					
Adaptive - Feeding, eating, dressing, and sleeping (ex., help hold a bottle; reach for a toy; help dress himself or herself).					
	Vision/Hearing	g Screenings (Check	( those that apply)		
Vision Concern Y □ N □ Screening Requested □ Screening Results: □ Pass Date of Screening: □ Screening Completed By: Follow Up Needed:	sed	Hearing Concern Y Newborn or Newborn or Date of Screen	☐ N ☐ Other Screening Requested ☐ Other Screening Results: ☐ Passed ☐ Referred eening: completed By:		
Eligible for ITP Services?: Eligible for Children's SC Comments:		Date			
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Child's Name: \_\_\_\_\_\_

Date Completed: \_\_\_\_\_

# 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.

Child/Family Photo

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)

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### **Outcomes for Child**

Date of IFSP: Up	Addendum / Date:  Updated Progress Statement / Date:				
Now that we have identified your child's interests and needs we will focus on what you would like your child to do.					
	o do in the next few months? (Functional Outcome)				
What is your child doing now? (Child's current level of function rel	ated to this outcome.)				
The progress statement must be measured within the context of	of everyday learning activities.				
How will we know we're making progress? What will be differe (Progress Statement/Criteria for Success)					
What strategies and resources will we use to make this happer routines, and where will it occur?)	n? ( <i>Who</i> will do <i>what</i> during <i>which</i> regular activities and				
Who will be involved? (Include names of all who will be involved)					
How did we do? (Review of Progress Statement/Criteria for S	uccess)  Comments Date:				
☐ Date: Achieved: We did it!	Comments Date.				
☐ Date: Continue: We are part way there. Let's	keep going.				
The situation has changed:					
☐ Date: Discontinue: It no longer applies.					
☐ Date: Revise: Let's try something different.					
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mulvidualized Family Service Plan Field Test 9/09	Date Completed.				

## **Outcomes for Parent/Caregiver**

Date of IFSP: Upo	Addendum / Date:  Updated Progress Statement / Date:				
This page documents what you and your family would like to achieve in order to support your child's development.					
Outcome # What specifically do we want to accomplis	h? (Functional Outcome)				
What is happening now?					
How will we know we're making progress? What will be different	nt? When do we hope to have this completed?				
(Progress Statement/Criteria for Success)					
What strategies and resources will we use to make this happen?	(Who will do what during which regular activities and				
routines, and <i>where</i> will it occur?)	with do what during which regular activities and				
Mho will be involved? (Include names and mhone mumbans)					
Who will be involved? (Include names and phone numbers)					
How did we do? (Review of Progress Statement/Criteria for Suc	ress)				
·	Comments Date:				
Date: Achieved: We did it!	oon going				
Date: Continue: We are part way there. Let's keep the situation has changed:	eep going.				
Date: Discontinue: It no longer applies.					
Date: Revise: Let's try something different.					
	<u> </u>				
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Idaho Infant Toddler Program	Child's Name:				

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#### **Outcomes for Service Coordination**

Date of IFSP:   Initial	Annual A	Addendum / Date:
Service Coordination is provided to all families enrolled in child and family access resources and supports. This pag through the early intervention system.		
Outcome #1 What do we want to accompl	ish? (Desired Outcome)	Start Date:
	,	Target Date:
		raiget Date.
Who will do what? (Strategies/Activities)		Review Date:
		Progress Code:
		Comments:
		Commente.
Outcome # What do we want to accompli	sh? (Desired Outcome)	Start Date:
<u>.</u>	,	Target Date:
Who will do what? (Strategies/Activities)		Review Date:
		Progress Code:
		Comments:
Outcome # What do we want to accompli	sh? (Desired Outcome)	Ota d Data
Trial do we want to document	GIT: (Desired Outcome)	Start Date:
		Target Date:
Who will do what? (Strategies/Activities)		Review Date:
		Progress Code:
		Comments:
This have published what stone the family and	taka in an ancarasa	
This box outlines what steps the family can Emergency Contact Plan:	take in an emergency.	Deview Data:
Line goney contact i tall.		Review Date:
		Progress Code: Comments:
Progress Review Codes: N = New	C = Continue A = Achieved	R= Revised D = Discontinued
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#### **Transition Planning** Date of IFSP: \_\_\_\_\_ Addendum / Date: ☐ Initial ☐ Annual Date Child Turns 3: This page describes transition activities that you and your family can expect over the next year. Transitions are big changes that occur in your early intervention services or family's life. Transitions include things like: bringing your child from the hospital to home, changing a child care provider, going to preschool, etc. This plan can help you explore options, changes in service delivery, or identify new skills your child may need to be most successful in a new setting. **Date Completed** Transition activities Who is responsible? Transition For Children Who May Be Eligible For School District Services 27-30 Notify school district of potentially eligible child Target Date: Date completed: months Steps: (Who will do what?) 27-33 Target Date: Schedule and hold transition planning meeting Date completed: months Steps: (Who will do what?) Complete necessary evaluations 30-36 Target Date: Date completed: months Steps: (Who will do what?) Attend eligibility meeting upon invitation 30-36 Target Date: Date completed: months Steps: (Who will do what?) Schedule family visits if appropriate 30-35 Target Date: Date completed: months Steps: (Who will do what?) 33-36 Target Date: Date completed: Attend IEP meeting upon invitation months Steps: (Who will do what?) **Post Transitional Activities** 36+ Target Date: Date completed: months Steps: (Who will do what?) Start Date: Date completed: Other

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

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Date Completed:

#### **Summary of Services** ☐ Initial ☐ Annual Addendum / Date: \_\_\_\_\_ Date of IFSP: \_\_\_\_\_ 6 Month review \_\_\_\_\_ **Funding** Method Source Person(s)/ (Group/Individual) Early \*NE **Start Date** Frequency Agency(ies) If Medicaid. **Intervention Services** (How Often) **End Date** Y or N MID# Intensity Responsible (Total min/month) \*NE: If No, please complete the Natural Environment Justification page. **Diagnosis Description:** Medical Code: Educational Code: ITP Code: Consent by Parents/Guardians for Provision of Services I participated in the development of this plan. I understand that with receipts of my Procedural Safeguards, this plan serves as Prior Written Notice for evaluation, placement, and/or the provision of listed services. 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: (\*Required for Medicaid Reimbursement) 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: \_\_\_\_\_

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Date Completed: \_\_\_\_\_

#### 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)
Explanation of Why Outcome Cannot be Achieved in a Natural Environment:		
Plan and Timeline for Moving Service(s) and/or Support(s) into Natural Environments:		
Projected Review Date:		
Date of Review:		
Participants (including Parents/Caregiver):		
Recommendations:		
nessimilaridations.		
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