Individualized Family Support Plan (IFSP)

Your Family's Information

Child's Information

Child's Name: _____ _____ _____ _____
Last First MI AKA

DOB: _____ Child ID #: _____ Gender: _____

Caregiver(s)

Caregiver Type: _____
Caregiver Name(s): _____
Address: _____
City: _____ Zip Code: _____ County: _____
Cell Phone: _____ Home Phone: _____ Work Phone: _____ Ext: _____
Best time to call: _____ Email: _____

Caregiver Type: _____
Caregiver Name(s): _____
Address: _____
City: _____ Zip Code: _____ County: _____
Cell Phone: _____ Home Phone: _____ Work Phone: _____ Ext: _____
Best time to call: _____ Email: _____

Language

Child's Primary Language/Mode of Communication: _____ _____
Primary Language Used in Home/Mode of Communication: _____ _____
Is an Interpreter needed for the family? _____

IFSP Information

Referral Date: _____ IFSP Periodic Due Date: _____ _____ _____ _____
Initial IFSP Due Date: _____ Actual Periodic Date: _____ _____ _____ _____
Actual Initial Date: _____ Annual Due Date: _____
Current IFSP Date: _____ Actual Annual Date: _____
Current IFSP Type: Date Child turning 3: _____
○ Interim ○ Initial ○ Periodic ○ Annual Transition Due Between: _____ & _____

Contact Information

Agency: _____
Service Coordinator: _____
Phone: _____ Ext: _____ Fax: _____ Email: _____
Address: _____ City: _____ Zip: _____
Family Resource Specialist: _____
Phone: _____ Ext: _____ Fax: _____ Email: _____
Address: _____ City: _____ Zip: _____

Child Name: , - Service Coordinator:
Child DOB: IFSP Date:

Getting to Know Your Child and Family

Young children learn best through routines and activities that they are interested in and participate in often. It is helpful for us to know where and how your child regularly spends time so that we can develop this plan. As you and your Service Coordinator talk about your daily routines, she/he will summarize that information below.

What brought you to Early Steps?

Family: Who lives in your household? Add Family Member

Name:	Relationship:
	Self (Child)

Routine/Participants: Your child is able to complete the following routines:

Routines	Location	Caregivers Involved	Times	Ability to Accomplish	What do you and your child enjoy about this activity? What makes this routine/activity challenging or difficult?
Morning Activities					
Getting up in the morning					
Dressing					
Toileting					
Nap Time					
Inside Play					
Other:					
Other:					
Daytime Activities					
Traveling in the car					
Childcare					
Going from one activity to another					
Outside play					
Going out to eat					
Community Activities					
Religious services					
Attending medical appointments/ Doctor visits					
Grocery Shopping					
Other:					
Other:					
Evening Activities					
Meal Time					
Bath Time					
Family Games					
Going to Bed					
Other:					
Other:					

Successes: What success would you like to share about your child's development? What are your favorite family experiences with your child?

Concerns: What are your most important concerns about your child's development? What difficulties does your family/child experience during your daily routine?

Priorities: What are your priorities? What would you like Early Steps to focus on?

Additional Information: Is there anything else you would like to share?

Child Name: , -
Child DOB:

Service Coordinator:
IFSP Date:

Health Status & Insurance

Date information gathered: _____ Chronological age: _____ months

Primary Pediatrician			Other Physician(s)	Physician Type	Phone
Office Name					
Address					
City	State FL	Zip			
Phone	Fax				

Primary Insurance	Member ID	Group/MED Type	Policy Holder	DOB
Secondary Insurance				

Bill Private Insurance: _____

Tell us about your child's health:

Was your child born full term? _____ Date of child's last well check: _____

How many weeks? _____ Birth Weight: 0 0 oz. or 0 g Are immunizations current? _____

Is your child currently on medication? _____ If so, what types and why? Please List:	Does your child have any medical conditions and/or diagnosis? _____ If yes, please describe:
Has your child been hospitalized? _____ Please describe when & why:	Describe any family medical history that may be important for the team to know:
Does your child have allergies? _____ Describe:	Please share information about any medical/therapy evaluations your child has received:
Your child's nutritional habits/preferences. Describe:	Your child's sleep patterns (bedtime, naps, hours of sleep) Describe:
Hearing When was your child's most recent hearing screening? _____ What were the results?	**Vision** When was your child's most recent vision screening? _____ What were the results?
Do you have concerns about your child's hearing? _____ Describe:	Do you have concerns about your child's vision? _____ Describe:

Developmental Screening: Was a developmental screening conducted today? ▼

Please list the tools/methods used:

As a result of the screening, there are possible delays in the following areas of development:

☐ Adaptive ☐ Social-Emotional ☐ Communication ☐ Motor ☐ Cognitive ☐ None

Person completing screening (Print Name): _____

Next Steps:

Child Name: , -
Child DOB:

Service Coordinator:
IFSP Date:

Your Child's Service Coordination/Targeted Case Management Plan

Your Service Coordinator's name is . He/she can be reached by phone at and by email at . The family Resource Specialist, , is also available to provide parent support. He/she can be reached at or by email at .

Targeted Case Management Review Date(s): _____ _____ _____

Below are medical or additional supports your child and family receive or would like help receiving that are not required or covered by Early Steps:

Medical or additional supports your child of family receives or would like assistance with:

Child Care/Enrichment	Currently Receiving	Would Like Help Receiving	NA
Before/After Childcare	☐	☐	☐
Camps	☐	☐	☐
Child Care/Enrichment	☐	☐	☐
Early Head Start/Head Start	☐	☐	☐
Parenting Classes	☐	☐	☐
Income Assistance			
Emergency Financial Support	☐	☐	☐
Food Stamps/SNAP	☐	☐	☐
Low Income Housing	☐	☐	☐
Public Assistance/TANF	☐	☐	☐
SSI/SSDI	☐	☐	☐
Transportation	☐	☐	☐
WIC	☐	☐	☐
Medical/Health			
Counseling Assistance	☐	☐	☐
Dental Services	☐	☐	☐
Home Health Care	☐	☐	☐
Immunizations	☐	☐	☐
Medical Insurance	☐	☐	☐
Mental Health Care	☐	☐	☐
Substance Abuse	☐	☐	☐
Nutrition Classes	☐	☐	☐
Prenatal Care	☐	☐	☐
Primary Health Care	☐	☐	☐
Other			
Accessibility	☐	☐	☐
Adult Education	☐	☐	☐
Equipment	☐	☐	☐
Recreation Programs	☐	☐	☐
Safety	☐	☐	☐
Support Groups	☐	☐	☐
Other:	☐	☐	☐
Other:	☐	☐	☐

Additional Notes:

Your Child's Service Coordinator/Targeted Case Management Goals:

Add Referral

Person Responsible for Providing Assistance or Support	Date of Referral/Activity	Agency/Individual to Whom Child/Family is Referred	Referrals/Activities to be Completed by Service Coordinator

Child Name: , - Service Coordinator:
Child DOB: IFSP Date:

Your Child's Assessment/Eligibility Determination Part I

For children to be active and successful participants at home and in the community, they need to develop skills in the three functional areas described below. We use this information about your child's abilities and your concerns and priorities to understand your child's progress.

Date of evaluation/assessment: _____ Chronological Age: _____ Months

Instruments/Sources Used:

Functional Areas		Activities Your Child Does Well What are some things your child likes to do? What skills does your child demonstrate or is beginning to demonstrate?	Activities Your Child Finds Difficult What are skills that your child does not do or skills that are difficult for your child? In what activities or skill areas does your child need support and/or practice?	Your Child's developmental levels based on the evaluation and assessment:
DEVELOPLING POSITIVE SOCIAL-EMOTIONAL SKILLS	This includes your child's ability to engage others including developing relationships, self-soothing strategies for becoming and remaining calm, getting along with others, and expressing feelings.			**Social/Emotional:** _____ Score ☐ Indicates an area of delay as defined by Early Steps
ACQUIRING AND USING KNOWLEDGE AND SKILLS	This refers to your child's ability in areas such as thinking, reasoning, remembering, problem solving, number concepts, and counting. It also includes skills related to language and literacy.			**Communication:** _____ Score ☐ Indicates an area of delay as defined by Early Steps **Cognitive:** _____ Score ☐ Indicates an area of delay as defined by Early Steps
USING APPROPRIATE ACTIONS TO MEET NEEDS	This includes your child's ability to take care of basic needs such as getting from one place to another, dressing, feeding, toileting, and using tools (forks, toothbrushes, crayons).			**Gross Fine Motor:** _____ Score ☐ Indicates an area of delay as defined by Early Steps **Self Help:** _____ Score ☐ Indicates an area of delay as defined by Early Steps

Additional Information Regarding Eligibility/Assessment:

Your Child's Assessment/Eligibility Determination Part II
Vision and Hearing Status:
Observations/Comments:
Eligibility:
Additional information regarding eligibility:

Assessor: _____ Discipline: _____ Signature: _____

Assessor: _____ Discipline: _____ Signature: _____

Assessor: _____ Discipline: _____ Signature: _____

Assessor: _____ Discipline: _____ Signature: _____

Assessor: _____ Discipline: _____ Signature: _____

*Indicates the appropriate license professional member(s) of the IFSP team providing support and direction, if applicable.

Outcomes

Outcomes are the benefits for your child and family as a result of Early Steps services and supports based on your priorities. The team will develop strategies and timelines to determine progress towards achieving the outcomes.

Outcome # _____

Given what you've shared about your family's daily life, what would you like to see happen in your daily routines as a result of Early Steps services?

This outcome is related to the following functional area(s):

Please describe how progress will look in three months:

Please describe how progress will look in six months:

Strategies: Below are the steps to accomplish this outcome and the role of each team member:

Action Steps	Team Members

IFSP Review: _____ **Review Date(s):** _____ _____ _____

☐ We did it! ☐ We're making progress ☐ Let's make adjustment ☐ No longer needed ☐ Postponed

Progress: Please describe progress toward meeting this outcome.

Please describe the next steps:

Add Outcome

Child Name: , - Service Coordinator:
Child DOB: IFSP Date:

Services Needed to Achieve Early Intervention Outcomes

The below services are recommended by your team to support your family in meeting the developmental needs of your child. You have the right to accept or decline some or all the recommended services.

Add Early Steps Service

Service Description	Outcome #	Frequency	Intensity (Minutes)	Provider Name & Phone	Primary Service Provider	Location	Auth. Start Date	Auth. End Date	Date Services Must Start by	Payer

Non-Natural Environment Justification

Services must be provided in day-to-day routines, activities, and places that promote learning opportunities for your child and family. This means settings, including home and community settings, that are natural or typical for your child's age peers (natural environment). As a team, we decided outcomes cannot be met in a natural environment due to the following individualized reasons:

Diagnosis Codes:

ICD-10 Codes	ICD-10 Description

Medical Necessity: If your child is a Medicaid recipient, the services reimbursed by Medicaid must be medically necessary. The following is an explanation of the medical necessity of your child's services, if applicable:

Complete below if using as the Plan of Care for Therapy Services:

The services above are medically necessary: _____ Date: _____
(Signature)

Title: _____
(Primary Care Provider, ARNP, Physician's Assistant, or a designated physician specialist)

Plan Approval

☐ I participated fully in the development of this plan.
☐ A copy of my procedural safeguards (Summary of Family Rights) has been explained and provided to me.
☐ I give consent for all of the services described in this Individualized Family Support Plan (IFSP) to be provided as written.
☐ I do not provide consent for the following services recommended by my IFSP team:

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Consent for Services for Children in Custody of Department of Children and Families (DCF) Under Chapter 39, F.S.

I give consent for medical care and treatment per Section 743.0645, Florida Statutes, and as modified in this IFSP

DCF Caseworker/Designee Signature: _____ Date: _____

Transition

The Transition plan outlines the steps and services to support your child and family as you leave Early Steps at age three.

Preparing for Your Transition Conference

The following are options your family is interested in after your child turns three:

- ☐ Local school district (Pre-K)
- ☐ Head Start
- ☐ Agency for Persons with Disabilities
- ☐ Early care and education programs
- ☐ Other: _____

☐ The Understanding Notification Brochure was provided. Date: _____

Notification was provided to the local school district. _____ Date: _____

Notification was provided to the Department of Education. _____ Date: _____

Additional information regarding Notification, if applicable:

Your Transition Conference

Transition Conference Date: _____

What are your most important questions or concerns regarding your child's transition from Early Steps?

The following activities will occur to address your questions and concerns:

The below agency/programs provided information regarding their services that included the evaluation/eligibility process:

The following activities will support your child's transition into a new setting/environment: Add Activities

Family will:	Timeline	Agency/Program will:	Timeline	Service Coordinator will:	Timeline

We attended the transition conference and participated in the development of this transition plan.

Parent/Guardian	Parent/Guardian
Service Coordinator	Local School District Representative
Program/Agency Representative	Program/Agency Representative
Other	Other