Infant & Toddler Connection of Virginia

Individualized Family Service Plan (IFSP)

NAME OF LOCAL ITC

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| **Child and Family Information** | | | | | | |
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| **Child’s Name:** | | | | **Date of Birth:** | | |
| **Gender:**  Male  Female | | | | **Child’s County or City:** | | |
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| **IFSP Date:** | | **Initial**  **Annual #** | | | **Date 6-mo. Review Due:** | |
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| **Date(s) Review(s) Completed:** | | | | | | |
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| **Family’s Primary Language and/or Mode of Communication:** | | | | | | |
| **Child’s (if different):** | | | | | | |
| **Translator:** | | | | | | |
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| **Medicaid Number (optional):** | | | | | | |
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| **Parent’s and/or Other Family Member’s Name, Address, Phone and Other Contacts:** | | | | | | |
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| **Service Coordinator’s Name, Agency, Address, Phone Number, Email and Fax Number:** | | | | | | |
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| Early Intervention services are provided to eligible children and their families in compliance with  Part C of the federal *Individuals with Disabilities Education Act.* | | | | | | |

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| **Referral Information, Medical History and Health Status** |
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| **Gestational Age (in weeks):** |
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| **Referral Information and Medical History:** |
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| **Health Status:** |
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| **Daily Activities and Routines** |
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| Early intervention supports and services are designed to fit into your family’s life and take place as part of the daily activities of your child.   * Things your child does every day (or every week) * Activities your child enjoys * Activities or times of the day that are difficult or frustrating for you or your child (if any) * Places you and your child go (or would like to go) * Things you would like to do as a family, but cannot do because of your child’s needs (if any) |
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| **DAILY ACTIVITIES AND ROUTINES** |
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| LIST EASIEST OR MOST ENJOYABLE TIMES | |
| Routine 1: | What makes routine 1 go so well? Who is involved? |
| Routine 2: | What makes routine 2 go so well? Who is involved? |
| Routine 3: | What makes routine 3 go so well? Who is involved? |
| Routine 4: | What makes routine 4 go so well? Who is involved? |
|  | |
| LIST HARDEST OR MOST CHALLENGING TIMES | |
| Routine 1: | What makes routine 1 so challenging? Who is involved? |
| Routine 2: | What makes routine 2 so challenging? Who is involved? |
| Routine 3: | What makes routine 3 so challenging? Who is involved? |
| Routine 4: | What makes routine 4 so challenging? Who is involved? |

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| **Family Concerns, Priorities and Resources** | |
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| *To best support your child and family, it is helpful to understand what is important to your family. Your family’s concerns, priorities, and resources will be used as the basis for developing outcomes and identifying strategies and activities to address the needs of your child and family. You may share as much or as little information as you choose.* | Voluntary! Your child can still receive services if this section is not completed.       Parent initials if choosing not to include this information in the IFSP. |
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| **MY FAMILY’S CONCERNS**  Concerns I have (if any) about my child’s health and/or development. Information, resources, and/or supports I need or want for my child and/or family. | |
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| **MY FAMILY’S PRIORITIES**  The most important things for my child and/or family. | |
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| **MY FAMILY’S RESOURCES**  Resources that my child/family has for support, including people, activities, programs/organizations. | |
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| **Team Assessment** | |
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| **Assessment Type:** |  |
| **Assessment Date:** |  |
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| **Summary of Your Child’s Development** | |
| *Comparisons to same age peers are based on your child’s chronological age; the comparisons are not adjusted for prematurity. At the annual IFSP, this section will also document new skills your child has shown since the first IFSP.* | |
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| **Social/emotional skills, including social relationships:**  This area involves how your child interacts with adults and with other children, including how your child communicates his or her feelings. | |
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| Child’s development in relation to other children of the same age: | |
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| **Acquiring and using knowledge and skills, including early language/communication:**  This area involves how your child learns, including development of imitation, thinking, remembering, problem solving skills and using language (including gestures) to communicate what he or she knows and understands. | |
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| Child’s development in relation to other children of the same age: | |
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| **Use of appropriate behaviors to meet needs:**  This area involves how your child lets you know what he or she needs, how your child gets where he/she wants to go, and how your child is learning to take care of himself/herself, like dressing and undressing, feeding himself/herself, sleeping through the night, and using the toilet. This area also includes how your child is learning to follow directions about safety. | |
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| Child’s development in relation to other children of the same age: | |
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| **Age & Developmental Levels** | | | | | |
| **Age:** |  | **Adjusted Age:** |  | Cognitive: |  |
| Receptive Language: |  | Adaptive/Self-Help: |  | Gross Motor: |  |
| Expressive Language: |  | Social/Emotional: |  | Fine Motor: |  |

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| **Hearing and Vision Screenings** |
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| **Hearing** |
| Results of Virginia Part C Hearing Screening Tool:  No need for referral indicated  Monitor  Refer |
| Status (ear-specific information whenever possible): |
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| **Vision** |
| Results of Virginia Part C Vision Screening Tool:  No need for referral indicated  Monitor  Refer |
| Status (eye-specific information whenever possible): |

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| **Assessment Sources** | | | |
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|  | Assessment Tools |  |  |
|  | Hawaii Early Learning Profile (HELP) | HELP Strands |  |
|  | Early Learning Accomplishment Profile (E-LAP | Family Assessment |  |
|  | Receptive Expressive Emergent Language Scale (REEL) | Michigan |  |
|  | Battelle Developmental Inventory (BDI or Battelle). | Rossetti Infant-Toddler Language Scale | |
|  | Review of birth records and/or pertinent medical records less than six (6) months old from the primary care physician and other sources related to the child’s current health status, physical development (including vision and hearing), and medical history. Records reviewed: | | |
|  | Ongoing assessment (for annual team assessment) | | |
|  | Parent report | | |
|  | Formal/informal observation | | |
|  | Informed clinical opinion | | |
|  | Other – Specify: | | |

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| **ASP Participants** | |
| The following people participated in the assessment for service planning (ASP): | |
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| **Family Members** | |
| NAME | |
| Parent/Family Member | |
| NAME | |
| Parent/Family Member | |
|  | |
| **Other ASP Attendees** | |
| NAME + CREDENTIALS | |
| Service Coordinator | |
| NAME + CREDENTIALS | |
| Occupational Therapist  Physical Therapist  Speech-Language Pathologist | Educator/Special Educator  Nurse  Other |
| NAME + CREDENTIALS | |
| Occupational Therapist  Physical Therapist  Speech-Language Pathologist | Educator/Special Educator  Nurse  Other |
| NAME + CREDENTIALS | |
| Occupational Therapist  Physical Therapist  Speech-Language Pathologist | Educator/Special Educator  Nurse  Other |
| NAME + CREDENTIALS | |
| Occupational Therapist  Physical Therapist  Speech-Language Pathologist | Educator/Special Educator  Nurse  Other |

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| **Information from Outside Assessments** |
| Information from the following assessments completed outside the Infant & Toddler Connection of Virginia system was used to complete the assessment for service planning (Printed name, credentials, discipline, and organization): |
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| **Outcomes of Early Intervention** | | |
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| **Outcome** (Long-Term Goal) **# 1 – Service Coordination** (required) | | |
| In order to help your child and family receive the supports and services you need, your service coordinator will assure:   * that the IFSP addresses your identified concerns, priorities and resources; * the appropriateness and adequacy of supports and services; * your satisfaction with supports and services; and * that your child’s and family’s rights are protected. | | |
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| **Short-Term Goals** | **Target Date** | **Date Met** |
| Assist your family with the development and ongoing review and revision of the IFSP. | Ongoing |  |
| Provide support and assistance to your family in addressing issues or concerns that emerge over time. | Ongoing |  |
| Provide information and support your family, as needed, in accessing routine medical care for your child. | Ongoing |  |
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| **Provide supports identified by your family to include resources for:** |  |  |
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| **Service Coordination Activities** *(Interventions)*:   * Maintain ongoing contact with you for service monitoring. * Phone calls/personal contacts with your family and with individuals/agencies that provide support, assistance, services. * Link your family with appropriate community resources. * Assist with problem solving. | | |

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| **Outcome** (Long-Term Goal) **#** | **Date Outcome Added:** | | |
| **Target Date:** | **Date Met, Changed or Ended:** | | |
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| **Acquisition:**  Describe skill or behavior desired to be achieved.  **Context** **or Setting within Everyday Routines and Activities:**  Identify routines/activity in which behavior occurs.  **Criterion for Achievement Over What Amount of Time:**  Describe frequency/duration/rate for the new skill/behavior stated over a specific time period. | | | |
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| **Learning opportunities and activities that build on your child’s and family’s interests and abilities:** | | | |
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| **Short-Term Goals** | | **Target Date** | **Date Met** |
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| **Interventions (Treatment procedures and/or modalities):** | | | |
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| **Services Needed to Achieve Early Intervention Outcomes** | | | | | | | | | |
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| **Service Plan** | | | | | | | | | |
| **Entitled Service** | **Frequency** | **Period** | **Length (Minutes)** | **Group (G)**  **Individual (I)** | **Method** | **Natural Environment/**  **Location** | **Projected Start Date** | **Projected End Date** | **Actual**  **End Date** |
| Service Coordination |  |  |  |  |  |  |  |  |  |
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| **Service Coordination:**  This is the minimum frequency and length of direct contact from your service coordinator. The frequency and length of service coordination provided will vary since service coordination is an active, ongoing process that changes based on your family’s priorities and needs. | | | | | | | | | |
| **Frequency:** Equals the number of times over the course of the period. | | | | | | | | | |
| **Period:** Is expressed as #DAY, #WEEK or #MONTH. | | | | | | | | | |
| **Length:** Is expressed in minutes and rounded to the nearest 15-minute increment. | | | | | | | | | |
| **Method:** A=Coaching, including hands-on as appropriate ⦁ B=Consultation ⦁ C=Assessment ⦁ D=Provision of assistive technology device | | | | | | | | | |
| **Natural Environment/Location**: Home/CC/CS = Home, Child Care, Community Setting ⦁ Other = Non-natural Setting | | | | | | | | | |
| **Payment arrangements for services are specified on the Family Cost Share Agreement form.** | | | | | | | | | |
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| **Justification of why early intervention outcomes can’t be achieved satisfactorily in a natural setting** and a plan with timelines and supports necessary to return early intervention services to natural settings: | | | | | | | | | |
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| **Reason for later projected start date.** For each service that is planned to start more than 30 calendar days after the family signs the IFSP, indicate whether the reason is family scheduling preference, team planned a later start date to meet child and family needs or other: | | | | | | | | | |
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| **Other Services** | | | |
| (Services needed, but not entitled under Part C, including medical services such as well baby checks, follow-up with specialists for medical purposes, etc.) | | | |
| **Service** | **Provider** | **Location** | **Steps to Assist in Securing Services** |
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| **Transition Planning** |
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| **The following information about transition is discussed beginning at the initial IFSP meeting**: |
| * Transition happens when your child leaves early intervention. The planning on this page will help you and your child move smoothly from early intervention to whatever comes next for your child. * Options after early intervention (examples: community programs like neighborhood nursery schools, Head Start, early childhood special education through the public schools). * Possible timing of transition:   + When your child reaches age level in all developmental areas and meets no other eligibility requirements for early intervention   + When your child reaches his/her third birthday, which is the end of eligibility for early intervention   + When and if your child begins early childhood special education services through the public schools (between age 2 and 3), if you are interested in those services. Children may not be served in early intervention and early childhood special education through the public schools at the same time. |
| This information was discussed on       (date) by       (initials of service coordinator) |
| **Important Dates for Transition Planning:**        – Target date for notification and referral to determine eligibility if you are interested in early childhood special education services through your local school system (referral must occur at least 90 days before the anticipated date of transition and must occur by April 1 of the year your child turns 2 by Sept. 30 if you want your child to begin school on the first day of the next school year).        (Date of child’s 3rd birthday) – Date on which your child is no longer eligible to receive early intervention. |

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| **Transition Plan** | | | |
| The transition activities completed will depend on your transition plans and family preferences. | | | |
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| **Transition Steps/Activities** | **Target Date** | **Complete Date** | **Initials** |
| 1. **Community Options**: Help your family explore community program options, which may include early childhood special education services, for your child |  |  |  |
| * 1. Provide information, including program contact information, about community options following early intervention, as desired by your family. |
| * 1. Arrange for visits to programs, as desired by your family. |
| * 1. Other steps/activities (e.g., if you are interested, provide names of other families, with their permission, who have transitioned to programs you are considering).   Information and support provided on community options: |
| 1. **Notification and Referral to the Local School Division and Virginia Department of Education**: At least 90 days before the anticipated date of transition and before April 1 of the year your child turns 2 by Sept. 30 if you want your child to begin school on the first day of the next school year – |  |  |  |
| * 1. Send your child’s name, date of birth and your contact information (name, address, phone number) to the       school division and Virginia Department of Education no earlier than       unless you disagree. Sending this information helps the school system to know who in the community may be eligible for special education services and is a referral to the local school division. |
| * I do not want my child’s name, date of birth and our contact information sent to the local school division and Virginia Department of Education for notification and referral. Opt-Out Date       Parent Initials |
| * I have changed my mind and agree to have this information sent to the local school division and Virginia Department of Education. Opt-In Date       Parents Initials |
| * 1. Date notification and referral sent to the local School Division:       to VDOE:   2. With your consent on a release of information form, send specific information about your child to the local school division (e.g., most recent eligibility determination and assessment reports, IFSP, etc.). |
| * Your consent obtained on release of information form on:       (date) |
| * Date information sent: |
| 1. **Support to Enroll in Other Programs:** Help your family enroll in a community program(s), other than the local school division, that you are interested in for your child, as available. |  |  |  |
| * 1. Help with getting and filling out paperwork and/or completing other steps necessary to enroll in the desired program: |
| * 1. If needed, with your consent on a release of information form, refer your child and send specific information about your child to the future service provider or program (e.g., most recent eligibility determination and assessment reports, IFSP, etc.) |
| * Your consent obtained on release of information form on       (date) |
| * Referral sent to       (program) on       (date) |
| * Date information sent: |
| * 1. Other steps/activities: |
| 1. **Transition Planning Conference**: At least 90 days, and up to 9 months if everyone agrees, before your child’s anticipated date of transition –   If your child might be eligible for early childhood special education services, plan for a transition conference between you, your service coordinator, and someone from your school division. |  |  |  |
| * 1. *Parental Prior Notice* form provided on       (date) |
| * 1. You  approve/  do not approve conference. |
| * 1. If you approve the conference, service coordinator ensures scheduling of conference and participation by required parties: |
| * Transition conference held on       (date) |
| * The following participated:  (You - required),  (early intervention- required),  (school division - required),  (other      ),  (other      ) |
| 1. **Transition Services**: Once your transition plans have been determined, help your child and family prepare, as desired by your family, for changes in supports and services so you can move smoothly out of early intervention and, if appropriate, into a new program. |  |  |  |
| * 1. Your child will transition to       on       (projected date) |
| * 1. Help your child and family get ready to transition out of early intervention and, if appropriate, into a new program/setting by: |

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| **IFSP Agreement** | |
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| **Parental Consent for Provision of Early Intervention Services:**  I have received a copy of family rights and information about family cost share under Part C of IDEA (Notice of Child and Family Rights and Safeguards Including Facts about Family Cost Share) along with this IFSP. These rights and payment policies have been explained to me and I understand them. I participated in the development of this IFSP and I give informed consent for the Infant & Toddler Connection of Virginia system and service providers to carry out the activity(ies) listed on this IFSP.  Consent means I have been fully informed of all information about the activity(ies) for which consent is sought, in my native language (unless clearly not feasible to do so) or other mode of communication; that I understand and agree in writing to the carrying out of the activity(ies) for which consent is sought; the consent describes that activity(ies); and the granting of my consent is voluntary and may be revoked in writing at any time.  I understand that the Infant & Toddler Connection allows parents to choose a specific service provider agency or service provider. The Infant & Toddler Connection will make available the IFSP service(s) needed by my child in a timely manner even if it is not with the provider of my first choice. If I wish to select a specific provider, then my consent to the IFSP service will begin once that provider is available and then services will be provided in a timely manner.  I understand that I may decline a service or services without jeopardizing any other early intervention service(s) my child or family receive through the Infant & Toddler Connection of Virginia system.  I understand that my IFSP will be shared within the local Infant & Toddler Connection of Virginia system, including with providers involved in assessment and/or in the development and/or implementation of this IFSP. | |
|  |  |
| Signature of *(check one)*:  Parent(s)  Legal Guardian  Surrogate Parent | Date |
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|  |  |
| Signature of *(check one)*:  Parent(s)  Legal Guardian  Surrogate Parent | Date |
|  |  |

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| --- | --- | --- |
| Other IFSP Participants | | |
| NAME + CREDENTIALS | | |
| Service Coordinator | | |
| NAME + CREDENTIALS | | |
| Occupational Therapist  Physical Therapist  Speech-Language Pathologist | Educator/Special Educator  Nurse  Other | In Person  Electronically  In Writing |
| NAME + CREDENTIALS | | |
| Occupational Therapist  Physical Therapist  Speech-Language Pathologist | Educator/Special Educator  Nurse  Other | In Person  Electronically  In Writing |
| NAME + CREDENTIALS | | |
| Occupational Therapist  Physical Therapist  Speech-Language Pathologist | Educator/Special Educator  Nurse  Other | In Person  Electronically  In Writing |
| NAME + CREDENTIALS | | |
| Occupational Therapist  Physical Therapist  Speech-Language Pathologist | Educator/Special Educator  Nurse  Other | In Person  Electronically  In Writing |
| NAME + CREDENTIALS | | |
| Occupational Therapist  Physical Therapist  Speech-Language Pathologist | Educator/Special Educator  Nurse  Other | In Person  Electronically  In Writing |
| Name of Translator (if used) | | |
| The following related documents are attached (if any): | | |
| Copies to: | | |

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| --- | --- | --- |
| **Physician Certification** (required in order to bill insurance)  I certify and approve that       services, as described in the IFSP, are medically necessary for this child. | | |
|  |  |  |
| Signature | Credentials | Date |

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| **IFSP Record Review** | | |
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| **Purpose of Review:**  6-Month Review  Upon Request by | **Review Date:** | |
|  | | |
| **Summary:** (*Include rationale for any changes resulting from this review*)*:* | | |
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|  |  | |
| **Changes:** | **Projected Change Start Date** | |
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| **Parental Consent for Provision of Early Intervention Services:**  I have received a copy of family rights and information about family cost share under Part C of IDEA (Notice of Child and Family Rights and Safeguards Including Facts about Family Cost Share) along with this IFSP Review Record. These rights and payment policies have been explained to me and I understand them. I participated in the development of this IFSP Review, and I give informed consent for Infant & Toddler Connection of Virginia system and service providers to carry out any changes listed on this IFSP Review Record.  I understand that the Infant & Toddler Connection allows parents to choose a specific service provider agency or service provider. The Infant & Toddler Connection will make available the IFSP service(s) needed by my child in a timely manner even if it is not with the provider of my first choice. If I wish to select a specific provider, then my consent to the IFSP service will begin once that provider is available and then services will be provided in a timely manner.  Consent means I have been fully informed of all information about the activity(ies) for which consent is sought, in my native language (unless clearly not feasible to do so) or other mode of communication; that I understand and agree in writing to the carrying out of the activity(ies) for which consent is sought; the consent describes that activity(ies); and the granting of my consent is voluntary and may be revoked in writing at any time.  I understand that I may decline a service or services without jeopardizing any other early intervention service(s) my child or family receives through the Infant & Toddler Connection of Virginia system.  I understand that my IFSP will be shared within the local Infant & Toddler Connection system, including with providers involved in assessment and/or development and/or implementation of this IFSP. | | |
|  | |  |
| Signature of *(check one)*:  Parent(s)  Legal Guardian  Surrogate Parent | | Date |
|  | |  |
|  | |  |
| Signature of *(check one)*:  Parent(s)  Legal Guardian  Surrogate Parent | | Date |
|  | |  |

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| IFSP Record Review (Cont.) | |
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| **If services increased on this IFSP review and my child is covered by private insurance:** | |
| My insurance should be billed for covered services. Unless my monthly cap is $0, I agree to continue paying for any applicable co-payments, deductibles and/or non-covered services in the manner indicated in the Charges section on the Family Cost Share Agreement form. I understand I can cancel this consent at any time by giving written notice to my child’s service coordinator. | |
| My insurance should no longer be billed for covered services. Unless my monthly cap is $0, I agree to pay for services in the manner indicated in the Charges section on the Family Cost Share Agreement form. I understand that I must complete and sign a new Family Cost Share Agreement form. | |
| I understand I can contact my service coordinator if I have questions about use of insurance or the payment arrangements on the Family Cost Share Agreement form. | |
|  | |
|  |  |
| Signature of *(check one)*:  Parent(s)  Legal Guardian  Surrogate Parent | Date |
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|  |  |
| Signature of *(check one)*:  Parent(s)  Legal Guardian  Surrogate Parent | Date |
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| --- | --- | --- |
| Other IFSP Participants | | |
| NAME + CREDENTIALS | | |
| Service Coordinator | | |
| NAME + CREDENTIALS | | |
| Occupational Therapist  Physical Therapist  Speech-Language Pathologist | Educator/Special Educator  Nurse  Other | In Person  Electronically  In Writing |
| NAME + CREDENTIALS | | |
| Occupational Therapist  Physical Therapist  Speech-Language Pathologist | Educator/Special Educator  Nurse  Other | In Person  Electronically  In Writing |
| NAME + CREDENTIALS | | |
| Occupational Therapist  Physical Therapist  Speech-Language Pathologist | Educator/Special Educator  Nurse  Other | In Person  Electronically  In Writing |
| NAME + CREDENTIALS | | |
| Occupational Therapist  Physical Therapist  Speech-Language Pathologist | Educator/Special Educator  Nurse  Other | In Person  Electronically  In Writing |
| NAME + CREDENTIALS | | |
| Occupational Therapist  Physical Therapist  Speech-Language Pathologist | Educator/Special Educator  Nurse  Other | In Person  Electronically  In Writing |

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| --- | --- | --- |
| **Physician Certification** (required in order to bill insurance)  I certify and approve that       services, as described in the IFSP, are medically necessary for this child. | | |
|  |  |  |
| Signature | Credentials | Date |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Addendum** | | | | | |
| *Refer to the IFSP Service Plan for service details.* | | | | | |
| **#** | **Service** | | **Service Provider (Name/Agency/Address/Phone)** | | **Current?** |
| 1 | Service Coordination | |  | | N |
| 2 |  | |  | | N |
| 3 |  | |  | | N |
| 4 |  | |  | | N |
| 5 |  | |  | | N |
| 6 |  | |  | | N |
| 7 |  | |  | | N |
| 8 |  | |  | | N |
| I was given the opportunity to choose from among provider agencies who work in my local system area and who are in my payor network. I may request to change service providers at any time by contacting my service coordinator. | | | | | |
|  | |  | |  | |
| For Services | | Signature of *(check one)*:  Parent(s)  Legal Guardian  Surrogate Parent | | Date | |
|  | |  | |  | |
| For Services | | Signature of *(check one)*:  Parent(s)  Legal Guardian  Surrogate Parent | | Date | |
|  | |  | |  | |
| For Services | | Signature of *(check one)*:  Parent(s)  Legal Guardian  Surrogate Parent | | Date | |
|  | |  | |  | |
| For Services | | Signature of *(check one)*:  Parent(s)  Legal Guardian  Surrogate Parent | | Date | |