



Infant & Toddler Connection of Virginia
Individualized Family Service Plan (IFSP)
Local System Name Here

Section I: Child and Family Information

Child's Name: _____ Date of Birth: _____

Gender: M F Child's County or City of Residence: _____

IFSP Date: _____ Initial Annual # _____ Date 6 mo. Review Due: _____

Date(s) Review(s) Completed: _____

Family's Primary Language and/or Mode of Communication: _____ Child's (if different) _____

Medicaid Number (optional): _____

Parent's and/or Other Family Member's Name, Address, Phone And Other Contacts:

Service Coordinator's Name, Agency, Address, Phone Number, Email and Fax Number:

Early Intervention services are provided to eligible children and their families in compliance with Part C of the federal *Individuals with Disabilities Education Act*.

Child's Name: _____

IFSP Date: _____ DOB: _____



Section II: Team Assessment

A. Referral Information, Medical History, Health Status:

B. Daily Activities and Routines

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)

C. Family Concerns, Priorities, and Resources:

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 initial if choosing not to include this information in the IFSP.

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.

MY FAMILY'S PRIORITIES

The most important things for my child and/or family.

MY FAMILY'S RESOURCES

Resources that my child/family has for support, including people, activities, programs/organizations

Child's Name: _____

IFSP Date: _____ DOB: _____



Section II: Team Assessment

D. 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.*)

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.*

Child's Development in Relation to Other Children the Same Age:

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.*

Child's Development in Relation to Other Children the Same Age:

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.*

Child's Development in Relation to Other Children the Same Age:

Section III:

Age & Developmental Levels

Age:		Adjusted Age		Cognitive	
Receptive Language		Adaptive/Self-Help		Gross Motor	
Expressive Language		Social-Emotional		Fine Motor	

Hearing:

Results of Virginia Part C Hearing Screening tool: No need for referral indicated Monitor Refer

Status (ear-specific information whenever possible):

Vision:

Results of Virginia Part C Vision Screening tool: No need for referral indicated Monitor Refer

Status (eye-specific information whenever possible):

Assessment Sources:

- Assessment Tools:
 - Hawaii Early Learning Profile (HELP)
 - Early Learning Accomplishment Profile (E-LAP)
 - Receptive Expressive Emergent Language Scale (REEL),
 - Battelle Developmental Inventory (BDI or Battelle).
- HELP Strands
- Family Assessment
- Michigan
- 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 other: _____

Child's Name: _____

IFSP Date: _____ DOB: _____



The following people participated in the assessment for service planning (ASP) *(Printed name, credentials, signature, date)*:

Parent

Name Credentials

Service Coordinator

Name Credentials

Discipline: Educator/Special Educator Occupational Therapist Physical Therapist Speech-Language Pathologist Nurse Other

Name Credentials

Discipline: Educator/Special Educator Occupational Therapist Physical Therapist Speech-Language Pathologist Nurse Other

Name Credentials

Discipline: Educator/Special Educator Occupational Therapist Physical Therapist Speech-Language Pathologist Nurse Other

Name Credentials

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Name Credentials

Discipline: Educator/Special Educator Occupational Therapist Physical Therapist Speech-Language Pathologist Nurse Other

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)*:

Child's Name: _____

IFSP Date: _____ DOB: _____



Section IV: Outcomes of Early Intervention

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.

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

Provide supports identified by your family to include resources for:

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.

Child's Name: _____

IFSP Date: _____ DOB: _____



Section V: Services Needed to Achieve Early Intervention Outcomes

ENTITLED SERVICE	FREQUENCY (# x/wk/ month/once)	LENGTH (# min/visit)	GROUP (G) / INDIVIDUAL (I)	METHODS** (a, b, c, d)	NATURAL ENVIRONMENT/ LOCATION (Must be a natural setting unless justified below)	PAYMENT 1. Family Fee 2. Insurance 3. Medicaid 4. State Funds 5. Local Funds 6. Part C	PROJECTED START DATE	PROJECTED END DATE	ACTUAL END DATE
1. Service Coordination	*	*		Service coordination					
2.									
3.									
4.									
5.									
6.									
7.									
8.									

* This is the minimum frequency and length of direct contact from your service coordinator. The frequency and length of service coordination actually provided will vary since service coordination is an active, ongoing process that changes based on your family's priorities and needs.

** Methods: a = Coaching, including hands-on as appropriate b = Consultation c = Assessment
d = Provision of assistive technology device

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:

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:

VI. 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 BE TAKEN TO ASSIST IN SECURING SERVICES

Child's Name: _____

IFSP Date: _____ DOB: _____



Section VII: Transition Planning

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

Transition Plan

The transition activities completed will depend on your transition plans and family preferences.

Transition Steps/Activities	Target Date	Date Completed	Initials Person Completing
1. Community Options: Help your family explore community program options, which may include early childhood special education services, for your child <ul style="list-style-type: none"> a. Provide information, including program contact information, about community options following early intervention, as desired by your family. Information provided on the following programs: _____ b. Arrange for visits to programs, as desired by your family. Programs visited: _____ c. 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): _____ 	_____	_____	_____
2. 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 – <ul style="list-style-type: none"> a. 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. <ul style="list-style-type: none"> • 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 _____ (parent initials and date) • I have changed my mind and agree to have this information sent to the local school division and Virginia Department of Education _____ (parent initials and date) b. Date notification and referral sent to the local School Division: _____ to VDOE: _____ c. 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.). <ul style="list-style-type: none"> • Your consent obtained on release of information form on _____ (date) • Date information sent _____ 	_____	_____	_____

Child's Name: _____

IFSP Date: _____ DOB: _____



Transition Steps/Activities	Target Date	Date Completed	Initials Person Completing
<p>3. 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.</p> <p>a. Help with getting and filling out paperwork and/or completing other steps necessary to enroll in the desired program: _____</p> <p>b. 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.)</p> <ul style="list-style-type: none"> • Your consent obtained on release of information form on _____ (date) • Referral sent to _____ (program) on _____ (date) • Date information sent: _____ <p>c. Other steps/activities: _____</p>	_____	_____	_____
<p>4. Transition Planning Conference: At least 90 days, and up to 9 months if everyone agrees, before your child's anticipated date of transition –</p> <p>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.</p> <p>a. <i>Parental Prior Notice</i> form provided on _____ (date)</p> <p>b. You <input type="checkbox"/> approve/ <input type="checkbox"/> do not approve conference.</p> <p>c. If you approve the conference, service coordinator ensures scheduling of conference and participation by required parties:</p> <ul style="list-style-type: none"> • Transition conference held on _____ (date) • The following participated: <input type="checkbox"/> (You - required), <input type="checkbox"/> (early intervention- required), <input type="checkbox"/> (school division - required), <input type="checkbox"/> (other _____), <input type="checkbox"/> (other _____) 	_____	_____	_____
<p>5. 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</p> <p>a. Your child will transition to _____ on _____ (projected date)</p> <p>b. Help your child and family get ready to transition out of early intervention and, if appropriate, into a new program/setting by:</p> <p>_____</p>	_____	_____	_____
<p>6. Exiting Early Intervention: Discharge your child from the local Part C system before his/her 3rd birthday</p> <p>a. <i>Parental Prior Notice</i> form is signed <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. Date of discharge/closure _____</p>	_____	_____	_____

Child's Name: _____
IFSP Date: _____ DOB: _____



Section VIII: IFSP AGREEMENT

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(s) of (check one): Parent(s) Legal Guardian Surrogate Parent

_____ Date

Other IFSP Participants (Printed name, credentials, signature, date):

Discipline: Service Coordinator

Name Credentials

Discipline: Educator/Special Educator Occupational Therapist Physical Therapist Speech-Language Pathologist Nurse Other

Name Credentials

Discipline: Educator/Special Educator Occupational Therapist Physical Therapist Speech-Language Pathologist Nurse Other

Name Credentials

Discipline: Educator/Special Educator Occupational Therapist Physical Therapist Speech-Language Pathologist Nurse Other

Name Credentials

Discipline: Educator/Special Educator Occupational Therapist Physical Therapist Speech-Language Pathologist Nurse Other

Name Credentials

Discipline: Educator/Special Educator Occupational Therapist Physical Therapist Speech-Language Pathologist Nurse Other

The following individuals participated electronically or in writing (specify which):

Translator/Interpreter (if used):

The following related documents are attached:

Copies to:

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

Child's Name: _____

IFSP Date: _____ DOB: _____

**Infant & Toddler
Connection of Virginia**



Child's Name: _____

IFSP Date: _____ DOB: _____



Section IX: IFSP Review Record

Purpose of Review: 6 month Review Upon Request by:

Review Date: _____

Summary (Include rationale for any changes resulting from this review):

Change(s):

Projected Start Date For Change:

Parental Consent

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(s) of (check one): Parent(s) Legal Guardian Surrogate Parent

Date

Child's Name: _____

IFSP Date: _____ DOB: _____



Section IX: IFSP Review Record

Review Date: _____

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(s) of (check one): Parent(s) Legal Guardian Surrogate Parent

Date

Other IFSP Participants (printed name, credentials, signature, date):

Discipline: Service Coordinator

Name Credentials

Discipline: Educator/Special Educator Occupational Therapist Physical Therapist Speech-Language Pathologist Nurse Other

Name Credentials

Discipline: Educator/Special Educator Occupational Therapist Physical Therapist Speech-Language Pathologist Nurse Other

Name Credentials

Discipline: Educator/Special Educator Occupational Therapist Physical Therapist Speech-Language Pathologist Nurse Other

Name Credentials

Discipline: Educator/Special Educator Occupational Therapist Physical Therapist Speech-Language Pathologist Nurse Other

The following individuals participated electronically or in writing (specify which):

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

Child's Name: _____

IFSP Date: _____ DOB: _____



Addendum

(Refer to corresponding number in Section V of the IFSP for service details)

#	Service	SERVICE PROVIDER (Name, agency, address, phone number)	Current?
1	Service Coordination		<input type="checkbox"/> N
			<input type="checkbox"/> N
			<input type="checkbox"/> N
2			<input type="checkbox"/> N
			<input type="checkbox"/> N
			<input type="checkbox"/> N
3			<input type="checkbox"/> N
			<input type="checkbox"/> N
			<input type="checkbox"/> N
4			<input type="checkbox"/> N
			<input type="checkbox"/> N
			<input type="checkbox"/> N
5			<input type="checkbox"/> N
			<input type="checkbox"/> N
			<input type="checkbox"/> N
6			<input type="checkbox"/> N
			<input type="checkbox"/> N
			<input type="checkbox"/> N
7			<input type="checkbox"/> N
			<input type="checkbox"/> N
			<input type="checkbox"/> N
8			<input type="checkbox"/> N
			<input type="checkbox"/> N
			<input type="checkbox"/> 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(s) of (check one): Parent(s) Legal Guardian Surrogate Parent Date

For Services # Signature(s) of (check one): Parent(s) Legal Guardian Surrogate Parent Date

For Services # Signature(s) of (check one): Parent(s) Legal Guardian Surrogate Parent Date