Infant & Toddler Connection of Virginia

TO: Family
Address
City, State & Zip

RE: Child's Name
ID Number

Confirmation of Scheduled Meetings/Activities ITCV-PS-5(0) 7/10

Date: _____

Dear: _____

I would like to confirm the following scheduled meeting(s)/activity(ies) that we have previously discussed for your child. This/these meeting(s)/activity(ies) have been scheduled at your convenience and can be rescheduled if needed.

o **Assessment for Service Planning**: To assist the IFSP team in identifying the early intervention supports and services necessary to meet your child's unique needs in all areas of development

_____ _____ _____
Date Time Place

o **Individualized Family Service Plan (IFSP) meeting**: To develop a family plan which includes outcomes, strategies, services and supports determined appropriate for your child and family by the team. An initial IFSP must be completed within 45 calendar days from the time your child was referred to Part C unless you extend this timeline to meet your family's needs.

_____ _____ _____
Date Time Place

Individuals who will participate in the scheduled meeting/activity are listed below. If they are not actually present at the meeting/activity, they will provide written or oral information. All of this information will be shared with you. You may invite anyone you wish to participate in the meeting/activity.

Names (Individual or Providing Agency)	Discipline

Please call me/us at _____ if you have any questions about the above information or schedule.

Sincerely,

_____
Name(s)/Title(s)

Note: *Parents are to receive a copy of this form.*

☐ Mailed ☐ Hand Delivered

DMH 888E 1048 R7/10(1)