

Individualized Family Service Plan (IFSP)

Referral Date: _____
 Person Referring: _____

Today's Date: _____
 Agency Initiating IFSP: _____

Child Information		Social Security #: _____ - _____ - _____
Child's Legal Name: _____	Nickname: _____	Date of Birth: ____/____/____ Sex: M <input type="checkbox"/> F <input type="checkbox"/>
Address: _____		Phone (home): _____ Phone: _____
School District of Residence: _____ County: _____		Medical Insurance #: _____
		Ancestry/Race: _____ Native Language: _____

Name	Relationship to Child	DOB Send Copy (optional)	Address	Phone (home)	Phone (work)

If parent/guardian needs an interpreter, give language: _____

Agencies and Persons Working with the Family (Fill in anytime)						
Start Date	Agency	Contact Person(s)	Phone	Type of Service or Title	End Date	Send Copy of IFSP

IFSP Meetings: Dates (Include last IFSP)					
Purpose: (Interim, Initial, Review, Annual, Transition)					

Child Eligibility

Early On® (Part C of IDEA) Yes No Based on: Established Condition _____ Developmental Delay _____

The IFSP is being used for:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Early On® (Part C of IDEA) | <input type="checkbox"/> Family Support Subsidy | <input type="checkbox"/> Supplemental Security Income | <input type="checkbox"/> Michigan Interagency Family Preservation Initiative |
| <input type="checkbox"/> Infant Support Services | <input type="checkbox"/> Children's Special Health Care Services | <input type="checkbox"/> Women, Infants, & Children | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Head Start | <input type="checkbox"/> Hospital Discharge Plan | <input type="checkbox"/> Special Education (IEP) | |

Child's Strengths and Needs

Child's Name: _____

Birth Weight: _____

Birthdate: _____

Number of weeks premature: _____

Strengths	Concerns
Date: _____	Date: _____

Area	Present Level of Development				Name/Type of Evaluation	Person Doing Evaluation	Agency
	Parent Input	Date	Professional Input	Date			
Medical/Health							
Hearing							
Vision							
Small Muscle Movement							
Large Muscle Movement							
Cognitive/Thinking							
Communication							
Social/Emotional							
Adaptive/Self-Help							

Developmental/Medical History (Include allergies, immunizations, and nutrition)

Family Information

Child's Name: _____

Date: _____

Information obtained with family's permission in personal interview(s) of _____ conducted by _____ on _____.
The family understands that they do not have to give any information on this page in order to receive services.

Resources and Strengths	Concerns	Family Priorities

Action Plan

Child's Name: _____
 Family Name: _____

Service Coordinator: _____
 Service Coordinator Phone #: _____

Date: _____
 I.D. #: _____

Early On® services must be provided in settings that are normal (natural) for infants/toddlers.

<input type="checkbox"/> <i>Interim</i> <input type="checkbox"/> <i>Initial</i> <input type="checkbox"/> <i>Review</i> <input type="checkbox"/> <i>Annual</i> <input type="checkbox"/> <i>Transition (See IFSP Guidelines)</i>						
OUTCOMES What would we like to have happen, by when, and how will we know it has happened?	WHAT & WHO What service or activity is needed and who will do it?	WHERE, WHEN & HOW Where the service will occur, how often, how long each time, individual (I) or group (G)?	Date Service		PAYOR Who will pay for it?	Review *
			Begins	Ends		Date/Rating/Comments

* Suggested Outcome Rating Scale: 1=Revised as new outcome; 2=No change, still a need; 3=Partly accomplished; 4=Accomplished outcome to family's satisfaction; NA= No longer a need

Action Plan

Child's Name: _____ Service Coordinator: _____ Date: _____

Family Name: _____ Service Coordinator Phone #: _____ I.D. #: _____

<input type="checkbox"/> <i>Interim</i>		<input type="checkbox"/> <i>Initial</i>		<input type="checkbox"/> <i>Review</i>		<input type="checkbox"/> <i>Annual</i>		<input type="checkbox"/> <i>Transition (See IFSP Guidelines)</i>	
OUTCOMES What would we like to have happen, by when, and how will we know it has happened?	WHO & WHAT What service or activity is needed and who will do it?	WHERE, WHEN & HOW Where will the service occur, how often, how long each time, individual (I) or group (G)?	Date Service		PAYOR Who will pay for it?	Review *			
			Begins	Ends		Date/Rating/Comments			

* Suggested Outcome Rating Scale: 1=Revised as new outcome; 2=No change, still a need; 3=Partly accomplished; 4=Accomplished outcome, to family's satisfaction; NA=No longer a need

Early On® services must be provided in settings that are normal for infants and toddlers. Explain the extent, if any, to which services are not provided in the child's natural environments. _____

Other Services - e.g. Medical Care, Financial, etc.					

<input type="checkbox"/> I have helped write this plan and understand it. <input type="checkbox"/> I agree to the services and plans of IFSP outcomes # _____. <input type="checkbox"/> I have received a copy and been informed of my Family Rights for <i>Early On</i> ® (including my right to mediation and/or a hearing if I disagree with the eligibility or service decision)	<input type="checkbox"/> I do not agree to any early intervention services at this time. <input type="checkbox"/> I do not agree with the assessment and/or IFSP outcomes (circle as appropriate) and: <input type="checkbox"/> request mediation and/or <input type="checkbox"/> request an impartial due process hearing
Signature of Parent/Guardian/Surrogate _____ / _____ Date _____	
Signatures/Title of People at IFSP Meeting (other than parents) _____ / _____ _____ / _____	

**Special Education Individualized Education Plan (IEP)
Birth through Two Years with IFSP**

Child's Name: _____
Service Coordinator: _____

Date: _____
Student I.D. #: _____

Special Instructions for IFSP/IEP

1. Purpose(s) of IEPC Meeting: Initial IEP Annual Review Redetermination of Eligibility Other _____
2. The existing IEP was reviewed and is being revised as appropriate to address:
 The results of any reevaluation conducted under this section;
 Information about the child provided to, or by, the parents;
 The anticipated needs of the child; or
 Other matters.
3. Date of MET: _____. The IEPC team considered the results of the initial or most recent evaluation.
4. The IEPC determines this child to be: Eligible as _____ Rule 340.17 _____ Ineligible
5. In the "Outcomes" column, for each special education goal/outcome (identify here by number: # _____), also list at least two short term steps (instructional objectives) to meet the goal, criteria for success, and method to check success including schedules for evaluation.
6. If a categorical program does not correspond with the child's eligibility, the IEPC must provide a rationale. The rationale is: _____
7. Describe supplementary aids and services to be provided to the child, or on behalf of the child, to advance appropriately toward attaining the annual goals. Include program modifications for personnel relating to these aids and services. Consider accessibility of physical facilities, specialized transportation, assistive technology devices, and assistive technology services. _____

Notice

Parent notice to participate in the IEPC meeting was sent on _____ (date). Additional attempts to arrange a mutually agreeable time and place:

Method of Contact: _____ By: _____ Date: _____

Check as appropriate:

- The special education goal/outcomes on the IFSP Action Plan # _____ (please indicate number of outcomes) consented to by the parent will be implemented as the IEP.
- The person responsible for implementing the IEP will be the Service Coordinator unless otherwise specified below:

Name: _____ Title: _____ Phone: _____

Resident District: _____ Agrees Disagrees _____ Date: _____
(Signature of Superintendent/Designee)

Operating District: _____ Agrees Disagrees _____ Date: _____
(If not Resident District) (Signature of Superintendent/Designee)

Consideration of Special Factors

The IEP team has -

- 1. In the case of a child whose **behavior** impedes his or her learning or that of others, considered strategies, including positive behavioral interventions, strategies, and supports to address that behavior;
- 2. In the case of a child with **limited English proficiency**, considered the language needs of the child as such needs relate to the IEP;
- 3. In the case of a child who is **blind or visually impaired**, provided for instruction in braille and the use of braille unless the IEP team determines, after an evaluation of the child that instruction in braille is not appropriate for the child;
- 4. Considered the **communication needs** of the child, and in the case of a child who is deaf or hard of hearing, considered the child's language and communication needs, opportunities for direct communication with peers and professional personnel in the student's language and communication mode, academic level, and full range of needs, including opportunities for direct instruction in the child's language and communication mode; and
- 5. Considered whether the student requires **assistive technology** devices and services.

Parent/Guardian/Surrogate Consent for IEP

As the Parent/Guardian/Surrogate:

- | | |
|--|---|
| <input type="checkbox"/> I agree to implementation of the special education program included in the coordinated service plan (IFSP Action Plan). | <input type="checkbox"/> I agree to placement of my child in a program that does not correspond with his/her eligibility. |
| <input type="checkbox"/> I have received a copy and been informed of all special education procedural safeguards. | <input type="checkbox"/> I do not agree with the special education eligibility and/or programs and services (circle as appropriate) and request an impartial due process hearing under R340.1724. |

Signed: _____
Parent/Guardian/Surrogate

Date: _____
Month/Day/Year

Additional Notice Requirements

The superintendent or designee of the operating district assures:

- That to the maximum extent appropriate, a person who has a disability, including a person who is assigned to a public or private institution or other care facility is educated with persons who do not have disabilities.
- That placement of a person who has a disability in special classes, separate schools, or the removal of a person who has a disability from the regular education environment occurs only when the nature or severity of the disability is such that education in a regular class using supplementary aids and services cannot be satisfactorily achieved.
- That a person whose disability is such that he or she requires special classes or facilities shall be placed in programs or services as close as possible to his or her home.
- That unless the IEP of a student with a disability requires some other arrangement, the student is educated in the school that he or she would attend if nondisabled.
- That in selecting the least restrictive environment, consideration shall be given to any potentially harmful effects to the student or the quality of services that the student needs.

Location (building) of program(s)/service(s): _____

Operating District: _____

Person responsible for implementation: _____

Implementation date: _____ (month/day/year)

Signed: _____
Superintendent or Designee of Operating District

Date: _____
Month/Day/Year