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| North Carolina Infant-Toddler Program  Individualized Family Service Plan |

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| Important Dates and Events |
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| **Child's Name:** | |  | | | | | | | |
| **Date of Birth:** | |  | | | | **Gender:  Male  Female** | | | |
| **Age at Referral:** | |  | | | | **Date of Referral:** | |  | |
| **IFSP Meeting Date:** | |  | | | **IFSP Start Date:** | |  | | |
| **Interim IFSP Date:** | |  | | **N/A** |  | |  | | |
| **Parent’s Name:** | |  | | | **Parent’s Name:** | |  | | |
| **Address:** | |  | | | **Address:** | |  | | |
| **City/State/Zip:** | |  | | | **City/State/Zip:** | |  | | |
| **Phone Number(s):** | | (   )    -  **Work  Home  Cell**  (   )    -  **Work  Home  Cell**  (   )    -  **Work  Home  Cell** | | | **Phone Number(s):** | | | | (   )    - |
|  | | | | **Work  Home  Cell**  (   )    -  **Work  Home  Cell**  (   )    -  **Work  Home  Cell** |
| **Email Address(es):** | |  | | | **Email Address(es):** | | | |  |
| **Language of parent:** |  | | | **Language of child:** | | | |  |
| **Resident School District:** | |  | | | | | | |
| **County:** |  | | | | | | | |

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| **Name** | **Relationship/Role** | **Phone Number** | **Address** | **Start Date** | **End Date** |
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**Your family’s concerns and priorities related to your child’s functioning and learning are the focus of your family’s Individualized Family Service Plan (IFSP) including the outcomes or goals. The information you choose to provide about your family’s strengths, resources and supports is very important and helpful as we all work together to achieve your desired outcomes for your child and family.**

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| **Date Family Assessment Completed:** | **Participants/Team Members:** | **Name of Family-directed Assessment Tool:** |

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| **Family’s Areas of Concern:** (Describe challenges or difficulties your child and/or family encounter during everyday activities and routines.) |

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| **Priorities of the Family:** (What could we start with right now that would make a difference for your family?) |

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| **Strengths and resources that assist in meeting the needs of your child and family:** (Include people that provide a support system for your family, such as relatives, family friends, co-workers as well as any agencies or services. Also include activities and outings that your child and family enjoy doing, such as playgroups, library story time, going to the park, having picnics, etc.) |

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| **Additional Information:** Is there anything else you would like for us to know that may be helpful as we plan supports and services to address what is most important to your child and family? |

**Child’s Present Skills and Abilities**:

This section of the IFSP provides a picture of your child’sstrengths and needs, the people, places and things that interest and motivates your child, and his/her likes and dislikes. The CDSA used several methods to look at your child’s development: standardized testing, record review, clinical observation, and parent report. The information that we gathered informs us about the skills and behaviors thatyour child has developed so far and how your child combines and uses these skills and behaviors to participate in daily activities. The skills and behaviors are divided into five domains (areas of development).

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| **Date(s) of Evaluation/Assessment:** | | | **Who Participated:** | |
| **Child’s Age:** | | **Adjusted Age:** | | |
| **Evaluation/Assessment Tools/Other Methods Used:** | | | | |
| **Developmental Domain** | **Skills & Abilities** | | | |
| **Things** **(child's name) Does Well** | | | **Challenges or Next Steps for** **(child's name)** |
| **Social/Emotional**  (Relating to other people, showing feelings, coping in situations throughout the day) |  | | |  |

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| **Adaptive**  (Ability to help self in daily activities, including feeding, dressing, toileting, sleeping, and getting needs met) |  |  |

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| **Cognitive**  (Thinking and learning, how the child solves problems) |  |  |

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| **Communication**  (Understanding words and gestures (receptive language), and using sounds, words and gestures (expressive language) |  |  |

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| **Physical Development**  (Using hands and using eyes and hands together with control and coordination (fine motor), the child’s strength, coordination and balance of muscles for movement (gross motor) |  |  |

**Child’s Health Information**:

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| **Summary of child’s current health status based on review of pertinent records and/or parent report. *(This may include child’s birth history, medical conditions or diagnoses, illnesses, hospitalizations, medications, vision and hearing status, or other information):*** |
| **What else should the team know about your child’s health so we can better plan and provide supports and services to your child and family?** |

**Child Assessment**

### Include a summary of functional assessments and observations of the child in his/her day-to-day environment. Information noted in this section may include summary from the initial child assessment or on-going child assessments. This section of the IFSP provides information that will be helpful in determining supports and services that are most appropriate to meet the specific child’s needs. List individuals involved in the assessment, procedures, results and child’s unique strengths and needs. Address all developmental domains if this is an initial child assessment.

### Functional child assessments:

* Are based upon on-going observation of child engaged in everyday activities with people they know, in natural settings
* **Engage families and caregivers as active participants**
* **Are individualized to address each child’s unique way of learning**
* **Reflect that development and learning are rooted in culture and supported by the family**
* **Integrate information across activity settings**

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| **Date** | **Description** |
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**Initial Evaluation and/or Child Assessment Results:**

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| **Evaluator’s Signature** |  | **Date** |
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| **Evaluator’s Signature** |  | **Date** |
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| **Evaluator’s Signature** |  | **Date** |

Outcomes must be measurable and reflect changes the family would like to see happen for themselves and their child.

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| **Outcome #** **What would you and your family like to see happen for your child/family in the next six months?** (The outcome must be functional and in the context of everyday routines and activities.) | **What’s happening now related to this outcome? What is your family currently doing that supports achieving this outcome? (**Describe your child and/or family’s functioning related to the desired change/outcome.) | | |
| **What are the ways in which your family and team will work toward achieving this outcome? Who will help and what will they do?** (Describe the methods and strategies that will be used to support your child/family to achieve your goals within your daily routines and activities. List who will do what.) | **How will we know we’ve made progress or if revisions are needed to the outcomes, strategies or services?** (What observable action or behavior will we see that will show us that progress is being made? Are there other procedures being used to measure progress? What realistic timelines will be used to determine progress?)  **Start Date:**  **Target Date:** | | |
| **How did we do?** (Review of progress statement/Criteria for success) | | |
| Date: |  | Achieved. We did it! |
| Date: |  | Continue. We are part way there. Let’s keep going. |
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| **The situation has changed:** | | |
| Date: |  | Discontinue. It no longer applies. |
| Date: |  | Revise. Let’s try something different. |
| Date: |  | Explanations/Comments |
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| **Primary Place of Early Intervention Services:** | | | | | | | | |
| **Early Intervention Service** | **Provider** | **Projected Start Date** | **Actual Start Date** | **Location/Most Natural Environment** | **Frequency/ Length/ Intensity/ Method** | **Payment Arrangement & Cost to Family** | **Anticipated Duration** | **Date Ended** |
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| **Other Services:** | **Provider:** | **Start Date:** | **End Date:** | **If needed, how EI will help family access other services:** | | | | |
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**Federal regulations require early intervention services be provided in natural environments and may only be provided in other settings when outcomes cannot be achieved satisfactorily in the natural environment. Justification to support the IFSP team’s decision that the outcome cannot be achieved satisfactorily in the natural environment must be documented below.**

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| **Outcome #** | **Service** | 1. **Discuss Efforts and Rationale Why Outcome Cannot be Met in Natural Environment** | 1. **Describe How the Intervention will be Generalized into Child’s and Family’s Daily Routines and Activities** | 1. **Identify Steps for Moving Intervention into a Natural Environment** |
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| **Transition Plans and Activities** | **Specific Action** | **Person Responsible** | **Date Started** | **Date Completed** |
| 1. **Meet to develop a transition plan, with discussion of parental rights and what “transition” means, with individualized steps, activities, and services. (Transition Planning Meeting- TPM)** |  |  |  |  |
| 1. **Discuss possible program options (including preschool special education services, Head Start, child care and other community services) that may be available when child is no longer eligible for Part C.** |  |  |  |  |
| 1. **Child Find Notification Date:**   **Name of School District:**  **The LEA/PSU where the child resides has been notified.** |  |  |  |  |
| 1. **Send specified information to Part B if parental consent is provided.**   **Yes**  **No** |  |  |  |  |
| 1. **Provide an opportunity to meet to review and revise the transition plan, as appropriate, and receive information from the LEA/PSU or other community program representatives.**   **(Transition Planning Conference- TPC)** |  |  |  |  |
| 1. **Establish procedures to prepare the child for changes in service delivery, including steps to help the child adjust to and function in a new setting.** |  |  |  |  |

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| **Prior Written Notice** | | | | |
| **Reason for Prior Written Notice:** Prior written notice must be provided to parents ten (10) days before the North Carolina Infant-Toddler Program (NC ITP) proposes, or refuses, to initiate or change the provision of early intervention services for your child and family. You may agree to have the proposed action(s) occur sooner and not wait the ten (10) days.  **Action Proposed:** To initiate the services listed on the IFSP for which consent is provided, according to the Service Delivery Plan.  **Reasons for Taking the Action**: After discussing all evaluation/assessment information, including family observations, concerns, priorities and resources, the IFSP team, including the family, agreed on the early intervention services and other supports to be provided to achieve the established outcomes. | | | | |
| **Notice of Rights and Procedural Safeguards** | | | | |
|  | ***(Initial)*** I have received a copy of ***NC Infant-Toddler Program Notice Child and Family Rights*** along with this prior written notice. This information includes all the procedural safeguards that are available, including a description of complaint procedures and the timelines for those procedures. These rights have been explained to me and I understand them. | | | |
| **Parental Consent for Provision of Early Intervention Services** | | | | |
| I participated in the development of this IFSP. I understand 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). I understand that my child will not receive the NC ITP services identified on the IFSP unless I give my written consent. | | | | |
| **Check one of the following:** | | | | |
| . | **I consent for the NC Infant-Toddler Program and service providers to provide the NC ITP services and activities listed on the IFSP.** | | | |
|  | **I decline for my child or family to receive: (specify)** | | |  |
|  | **— AND —** | | |  |
| **I consent for the NC ITP and service providers to provide all other NC ITP services and to carry out all other activities listed on this IFSP, EXCLUDING the service or services I have specified here.** | | | |  |
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| **Consent to Bill Insurance / Medicaid** | |  |  | |
|  | **(*initial)*** I have received a copy of the ***NC ITP System of Payment Notification***. The notifications related to billing private and public insurance benefits have been explained to me and I understand them. | | | |
|  | ***(initial)*** The insurance information on record for my child is current and accurate. | | | |
|  | ***(initial if applicable)*** I understand that if my child is covered by private insurance and Medicaid, private insurance must be billed first under Medicaid Policy, before Medicaid benefits can be accessed.  **Check one of the following:** | | | |
|  | I consent for the NC ITP and its authorized service providers to bill the private insurance and / or Medicaid on record for my child for all of the early intervention services as identified on this IFSP. I authorize the release of medical or clinical information necessary to process the insurance claim. **— OR —** | | | |
|  | I consent for the NC ITP and authorized service providers to bill the private insurance and / or Medicaid, on record for my child, for the early intervention services identified on this IFSP ***except*** for the following *(please specify)* | | | |
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| Parent/Guardian Signature and Date | |  | Parent/Guardian Signature and Date | |
|  | |  |  | |
| EI Service Coordinator Signature and Date | |  | Agency Representative or Designee Signature/Agency and Date | |
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| Other Signature and Date | |  | Other Signature and Date | |

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| **Review Date** | | |  | | | | | | | |
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| REVIEW CYCLE   Semi-Annual  Annual  Other | | | | | | | | | Target Date for Next Review | |
| **Prior Written Notice** | | | | | | | | | | |
| **Reason for Prior Written Notice:** Prior written notice must be provided to parents ten (10) days before the North Carolina Infant-Toddler Program (NC ITP) proposes, or refuses, to initiate or change the provision of early intervention services for your child and family. You may agree to have the proposed action(s) occur sooner and not wait the ten (10) days.  **Action Proposed:** To initiate or change the services listed on the IFSP for which consent is provided, according to the Service Delivery Plan.  **Reasons for Taking the Action**: After discussing all evaluation/assessment information, including family observation, concerns, priorities and resources, the IFSP team, including the family, agreed on the early intervention services and other supports to be provided to achieve the established outcomes. | | | | | | | | | | |
| **Notice of Rights and Procedural Safeguards** | | | | | | | | | | |
|  | | ***(initial)*** I have received a copy of ***NC Infant-Toddler Program Child and Family Rights*** along with this prior written notice. This information includes all the procedural safeguards that are available, including a description of complaint procedures and the timelines for those procedures. These rights have been explained to me and I understand them. | | | | | | | | |
| **Parental Consent for Provision of Early Intervention Services** | | | | | | | | | | |
| I participated in the development of this IFSP. I understand 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). I understand that my child will not receive the NC ITP services identified on the IFSP unless I give my written consent. | | | | | | | | | | |
| **Check one of the following:** | | | | | | | | | | |
|  | | **I consent for the NC Infant-Toddler Program and service providers to provide the NC ITP services and activities identified on this IFSP.** | | | | | | | | |
|  | | **I decline for my child or family to receive: (specify)** | | | | | |  | | |
| — **AND** — | | | | | | | |  | | |
| **I consent for the NC ITP and service providers to provide all other NC ITP services and to carry out all other activities listed on this IFSP, EXCLUDING the service or services I have specified here.** | | | | | | | |  | | |
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| **Consent to Bill Insurance** | | | |  | |  | | | | |
|  | | **(*initial)*** I have received a copy of the ***NC ITP System of Payment Notification***. The notifications related to billing private and public insurance benefits have been explained to me and I understand them. | | | | | | | | |
|  | | ***(initial)*** The insurance information on record for my child is current and accurate. | | | | | | | | |
|  | | ***(initial if applicable)*** I understand that if my child is covered by private insurance and Medicaid, private insurance must be billed first under Medicaid policy, before Medicaid benefits can be accessed | | | | | | | | |
|  | | **Check one of the following:** | | | | | | | | |
|  | | I consent for the NC ITP and authorized service providers to bill the private insurance and / or Medicaid on record for my child for all of the early intervention services as identified on this IFSP including increases in the frequency, length, duration, or intensity. I authorize the release of medical or clinical information necessary to process the insurance claim. **— OR —** | | | | | | | | |
|  | | I consent for the NC ITP and authorized service providers to bill the private insurance and/or Medicaid, on record for my child, for any new early intervention service or for any increase in the frequency, length, duration, or intensity for services identified during this IFSP review meeting, ***except*** for the following *(please specify)* | | | | | | | | |
| **Family Outcomes Summary Review** | | | | | | | | | | |
|  | At the semi-annual review, the Family Outcomes Survey was discussed. I was given the opportunity to complete the survey. | | | | | | | | | |
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| Parent/Guardian Signature and Date | | | | | Parent/Guardian Signature and Date | | |
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| EI Service Coordinator Signature/ and Date | | | | |  | | Agency Representative or Designee Signature/Agency and Date | | | |
|  | | | | |  | |  | | | |
| Other Signature and Date | | | | |  | | Other Signature and Date | | | |