MARYLAND INFANTS AND TODDLERS PROGRAM

Individualized Family Service Plan (IFSP)

Referral Date:	IFSP Meeting Date:	IFSP Meeting Type: ❑ Interim ❑ Initial ❑ Annual Evaluation

Child and Family Information

Child Name (First/Middle/Last):		
Birth Date:	ID Number:	MA Number:
Address:		Home Phone:
Parent/Guardian/Surrogate Name:		
Address:		Home Phone:
Address:		Work Phone:
E-mail:		Cell Phone:
Best Time to Contact:	Best Method of Contact: ❑ Home Phone ❑ Work Phone ❑ Cell Phone ❑ E-mail	

Team Participant Signatures

Each agency or person who has a direct role in the provision of early intervention services is responsible for assisting the eligible child and family to achieve the outcomes in this IFSP.

Service Coordinator	*Date*	*Evaluator/Assessor (or involvement through other means, as appropriate)*		*Date*
Interim/Alternate Service Coordinator	*Date*	*Other Participant*	*Agency/Title*	*Date*
Lead Agency Representative	*Date*	*Other Participant*	*Agency/Title*	*Date*
Parent(s)/Guardian/Surrogate	*Date*	*Other Participant*	*Agency/Title*	*Date*

Service Coordinator Information

If you have questions about this IFSP or any of the individuals working with your child and family, contact your service coordinator.

Service Coordinator Name:	
Agency:	
Address:	
Work Phone:	E-mail:

Projected IFSP Meeting Dates

Projected Date **Six Month IFSP Review**:
Projected Date **Annual IFSP Review Date**:
Projected Date Range **Transition Planning Meeting**:

Child Name:	ID Number:	IFSP Meeting Date:

PART I - INFORMATION ABOUT MY CHILD'S DEVELOPMENT

Section A - Health Information

General Health

What was your child's gestational age at birth? __________ Weeks __________ Days

What was your child's birth weight? __________ Pounds _________ Ounces OR _________ Grams

Who is your primary care physician or other health care professional?	Phone:

IMMUNIZATIONS

Do you have a copy of your child's immunization record? ❑ Yes ❑ No

*If **NO**, please indicate the strategies to be used to obtain a copy of your child's immunization record.*

Does the immunization record have the required immunizations for your child's chronological age? ❑ Yes ❑ No

If ***NO****,* what strategies will be implemented for your child to receive the required immunizations?

Indicate immunizations received (*immunizations in **BOLD** are required for public school):*

❑ **DTaP/DT** ❑ **Polio** ❑ **Hib** ❑ **HepB** ❑ **PCV7** ❑ Rotavirus ❑ MCV4 ❑ Hep A ❑ **MMR** ❑ **Varicella**

Indicate immunizations needed (*immunizations in **BOLD** are required for public school):*

❑ **DTaP/DT** ❑ **Polio** ❑ **Hib** ❑ **HepB** ❑ **PCV7** ❑ Rotavirus ❑ MCV4 ❑ Hep A ❑ **MMR** ❑ **Varicella**

LEAD SCREENING/TESTING

Has your child's lead level been tested? ❑ Yes ❑ No If ***YES***, what was the level? ____________________

Are there any concerns about your child's lead level? ❑ Yes ❑ No *If* ***YES****,* please explain. ________________________

____

NUTRITION

Are there any concerns about your child's eating, general nutrition or growth? ❑ Yes ❑ No

If ***YES****,* please explain.

GENERAL HEALTH CONCERNS

Is there anything about your child's health (special equipment, allergies, other mental or physical information) that the team should know about to better plan and provide services to your child and family?

Child Name:	ID Number:	IFSP Meeting Date:

PART I - INFORMATION ABOUT MY CHILD'S DEVELOPMENT

Section B - Present Levels of Development

Evaluation Status:	❑ Entry	❑ Interim (Birth to 3)	❑ Exit (Birth to 3)	❑ Interim (3 to Kindergarten Age)	❑ Exit (3 to Kindergarten Age)

Present Levels of Development

Area		Date of Assessment (MM/DD/YY)	Name of Assessment Instrument(s)	Chronological Age	Age Level/ Age Range	Qualitative Description
Cognitive	**Cognitive** (Playing, thinking and exploring)					
Communication	**Communication** (Understanding others and expressing myself)					
Social or Emotional	**Social or Emotional** (Emotions, feelings, and interacting with others)					
Adaptive	**Adaptive** (Eating, drinking, toileting, and doing things for myself)					
Physical	**Fine Motor** (Using my hands for play, feeding or other activity)					
Physical	**Gross Motor** (Moving my body to change position or location)					
Physical	**Hearing**	Did your child pass a Universal Newborn Hearing Screening? ❑ Yes ❑ No ❑ Not Applicable Has your child seen an audiologist for a full hearing evaluation? ❑ Yes ❑ No Are there any concerns about your child's hearing? ❑ Yes ❑ No Results of Evaluation/Observation:				
Physical	**Vision**	Has your child's vision been tested? ❑ Yes ❑ No Are there any concerns about your child's vision? ❑ Yes ❑ No Results of Evaluation/Observation:				

Child Name:	ID Number:	IFSP Meeting Date:

PART I - INFORMATION ABOUT MY CHILD'S DEVELOPMENT

Section C - Eligibility for Early Intervention Services

Eligibility

Your child is eligible for early intervention services based upon the results of the evaluation process.
Eligibility is based on the ONE category that is checked below.

❏ **AT LEAST A 25% DEVELOPMENTAL DELAY**

My child is eligible for early intervention services because my child is experiencing at least a 25% delay in one or more of the following developmental areas. **Check all that apply**:

❏ Cognitive ❏ Communication ❏ Social or Emotional ❏ Adaptive ❏ Physical: ___ Fine Motor ___Gross Motor

❏ **ATYPICAL DEVELOPMENT OR BEHAVIOR**

My child is eligible for early intervention services because my child is demonstrating atypical development or behavior in one or more of the following developmental areas, that is likely to result in a subsequent delay. **Check all that apply**:

❏ Cognitive ❏ Communication ❏ Social or Emotional ❏ Adaptive ❏ Physical: ___ Fine Motor ___Gross Motor

❏ **DIAGNOSED PHYSICAL OR MENTAL CONDITION WITH A HIGH PROBABILITY OF DEVELOPMENTAL DELAY**

My child is eligible for early intervention services because my child has a diagnosed physical or mental condition that has a high probability of resulting in developmental delay. This list is not all-inclusive. **Check all that apply**:

❏ Chromosomal disorder: ___ Down Syndrome ___ Other: ____________________
❏ Chronic lung disease (CLD)
❏ Congenital infection that is symptomatic (e.g., HIV)
❏ Inborn errors of metabolism associated with CNS involvement (e.g., maple syrup urine disease and galactosemia)
❏ Infants showing significant effects of maternal prenatal alcohol abuse (e.g., Fetal Alcohol Syndrome)
❏ Infants affected by intrauterine drug exposure requiring treatment or showing evidence of intrauterine growth restriction
❏ Intraventricular hemorrhage - Grades III or IV
❏ Lead poisoning, with a lead level of 20 ug/dL or greater
❏ Moderate to severe encephalopathy resulting from insult to the brain
❏ Neurodegenerative disorders with onset in infancy and early childhood (e.g., adrenoleukodystrophy, TaySachs disease)
❏ Periventricular Leukomalacia (PVL)
❏ Prematurity with birth weight of less than 1200 grams (2 lbs. 10 oz.)
❏ Seizure disorder where seizures are frequent or difficult to control or the underlying condition is associated with frequent cognitive impairment (e.g., infantile spasms)
❏ Sensory impairments
 ☐ Blind or visually impaired
 ☐ Deaf or hard of hearing
❏ Severe congenital malformations (e.g., meningomyelocele and congenital hydrocephalus)
❏ Surgical Necrotizing Enterocolitis (NEC)
❏ Other: ____________________
❏ Other: ____________________
❏ Other: ____________________

Child Name:	ID Number:	IFSP Meeting Date:

PART I - INFORMATION ABOUT MY CHILD'S DEVELOPMENT

Section D - Strengths and Needs

Strengths and Needs

A description of your child's unique strengths and needs provides valuable information when planning for early intervention services that will support the development of outcomes for your child and family.

MY CHILD'S STRENGTHS	MY CHILD'S NEEDS
What are some things my child likes to do? What are some things my child does well?	What are some things that are challenging for my child? What are some things my child does not know how to do yet?

Child Name:	ID Number:	IFSP Meeting Date:

PART II - INFORMATION ABOUT MY FAMILY

Section A - Concerns, Priorities, and Resources

Concerns, Priorities, and Resources

To best support your child and family, it is helpful to know about issues and concerns that are 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.

MY FAMILY'S CONCERNS	MY FAMILY'S PRIORITIES	MY FAMILY'S RESOURCES
Concerns I have about my child's health and development. Information, resources, supports I need or want for my child and/or family.	My hopes and dreams for my child. The most important things for my child and/or family right now.	Resources that my child/family has for support, including people, activities, programs/organizations.

❒ This information was gathered through a family-directed assessment using the following. **Check all that apply**:

- ❏ Locally developed family interview tool
- ❏ Routines-Based Interview (RBI)
- ❏ Ages and Stages Questionnaire (ASQ)
- ❏ Other tools/methods: ______________________________

❒ Family declined family-directed assessment.

Child Name:	ID Number:	IFSP Meeting Date:

PART II - INFORMATION ABOUT MY FAMILY

Section B - Natural Environments

Routines In Natural Environments

Early intervention services are provided in natural environments. A natural environment is a location where your child and family spend time, such as in the home, child care program, or other community setting. Natural environments are where typically developing children play and learn. The information below will help us determine the natural environment(s) in which your child and family will receive early intervention services.

Where does your child/family spend time? Check all that apply:

❏ Child's home ❏ Child care center ❏ Religious setting ❏ Family child care	❏ Early Head Start/Head Start ❏ Library ❏ Home of family member ❏ Toddler playgroup ❏ Judy Center	❏ Family Support Center ❏ Parent's place of employment ❏ Shelter ❏ Other: ________________________

What are some of the activities that you like to do together as a family?

Is there something you would like to do as a family, but cannot do at this time?

What are the daily routines of your child and family? Are some of these routines challenging? Are there other routines that your family would like to establish?

What are the barriers that keep your child and family from participating in your daily routines and activities?

How can the program best support your family in its desire to improve or create important routines?

Child Name:	ID Number:	IFSP Meeting Date:

PART III - MY CHILD/FAMILY OUTCOMES RELATED TO MY CHILD'S DEVELOPMENT

Child and Family Outcomes

Based upon information from your child's present levels of development and shared reports, your child's strengths and needs, your family's concerns, priorities, and resources, and your daily routines, this plan outlines what we want to accomplish and the specific steps required. Please discuss your priority outcomes for your child and/or family, including specific skills and context. A separate "Child and Family Outcomes" form is completed for each outcome.

OUTCOME	STRATEGIES/ACTIVITIES/ LEARNING OPPORTUNITIES	MEASURABLE CRITERIA
What would we like to see happen?	What steps need to be taken to help accomplish the priority outcome?	How will we know when the outcome is achieved?

TIMELINE	

PARTICIPANTS - *Who will be involved?*		
Name:	Title:	Phone/E-mail:
Name:	Title:	Phone/E-mail:
Name:	Title:	Phone/E-mail:
Name:	Title:	Phone/E-mail:

OUTCOME PROGRESS REVIEW

Review Codes: *Select the code that best applies.*
1- Proficient - *We did it!*
2- In process - *We're making progress.*
3- Needs development - *Let's make adjustments.*
4- No longer needed
5- Postponed

Code:	Date:	Initials:	Comments:

OUTCOME PROGRESS RESPONSE - *(ONLY NEEDED FOR PROGRESS REVIEW CODE 3)*

Review Codes: *Select the code that best applies.*
1- Revise outcome
2- Modify strategies/activities
3- Change service
4- Other: ___________________________

Code:	Date:	Initials:	Comments:

White: Early Intervention Record • *Yellow*: Family • *Pink:* Data Entry

Child Name:	ID Number:	IFSP Meeting Date:

PART IV - MY CHILD'S EARLY INTERVENTION SERVICES

Early Intervention Services

Early intervention services enhance the development of your child and the capacity of your family to meet the needs of your child. Each early intervention service supports your individual child and family outcomes. A separate "Early Intervention Services" form is completed for each service/support/setting.

TYPE OF SERVICE	SERVICE DESCRIPTION				SETTING
	Number of Sessions	Frequency	Intensity	Method	
Please specify:	❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ Other: ________	❑ Only ❑ Daily ❑ Weekly ❑ Monthly ❑ Yearly ❑ Quarterly ❑ Semi-Annually	*Number of minutes per session:* ❑ 15 ❑ 30 ❑ 45 ❑ 50 ❑ 60 ❑ 90 ❑ 120 ❑ 180 ❑ 240 ❑ Other: ________	❑ Group ❑ Individual	❑ Home *(Principal residence of child's family or caregivers)* ❑ Community-Based Setting *(Please specify):* ________ ❑ Other *(Please specify):* ________ Justification for Other Setting: ________

Type of Service		Community-Based Settings *(Where children without disabilities are typically found)*		Other Settings *(Not community or home-based)*
Audiology Family Counseling/Training Health Medical (diagnosis & evaluation only) Nursing Nutrition Occupational Therapy Physical Therapy	Psychological Respite Care Social Work Special Instruction Speech/Language Therapy Vision Services Other	Child care center (including family day care) Preschool program Regular nursery school Early childhood center Early Head Start/Head Start Judy Center Library	Grocery store Park/Playground Restaurant Community/Recreation Center Parent's place of employment Shelter Other	Early Intervention Center/Class for children with disabilities Service Provider Location (e.g. Outpatient, Audiologist) Hospital (Inpatient) Residential facility Other

Financial Responsibility: Check ***one*** agency responsible for payment of services.
❑ Local School System
❑ Local Health Department
❑ Local Department of Social Service
❑ Other (Please specify): ________________

Provider Agency: Record the name of the agency providing the service. Use the standard text designation within each agency.
____

Reimbursement Source: Check ***one*** reimbursement source *only* when the agency designated as financially responsible intends to request payment for the service from another source.
❑ Medical Assistance
❑ Other (Please specify): ________________

Provider Name/Phone Number: Record the name and phone number of the individual providing the service.
____

Projected Service Initiation Date: Record the date on which the service is projected to begin.
________________ MM/DD/YY

Projected Service Review Date: Record the projected date on which the service will be reviewed.
________________ MM/DD/YY

Projected Duration: Record the time period that the service will be provided.
________________ MM/YY

Service Ending Date: Record the date on which the service ends.
________________ MM/DD/YY

Child Name:	ID Number:	IFSP Meeting Date:

PART IV CONTINUED - MY CHILD'S EARLY INTERVENTION SERVICES

Early Intervention Services (continued)

ASSISTIVE TECHNOLOGY

Does my child need assistive technology services or devices to increase, maintain, or improve his/her functional capabilities? ❑ Yes ❑ No

Types of Assistive Technology. Check ***all*** that apply:

- ❑ Activities of Daily Living (ADL)
- ❑ Adaptive Computer Hardware
- ❑ Adaptive Computer Software
- ❑ Auditory Aids
- ❑ Augmentative and Alternative Communication Device (AAC)
- ❑ Environmental Control Units (ECUs)
- ❑ Mobility Aids
- ❑ Play, Recreation, and Leisure Aids
- ❑ Seating and Positioning
- ❑ Transportation/Safety Aids
- ❑ Vision Aids
- ❑ Other____________________

Provider

Provider Name:	
Phone:	E-mail:

TRANSPORTATION

Does this plan include the transportation necessary to enable my child and/or family to receive early intervention services? ❑ Yes ❑ No

Types of Transportation:

- ❑ Parent with reimbursement
- ❑ School Bus
- ❑ Cab/Taxi
- ❑ Public Transportation with reimbursement
- ❑ Other (Please Specify)____________________

Is any special equipment needed for transporting my child? ❑ Yes ❑ No
If ***YES***, specify the type of equipment: ____________________

Provider

Provider Name:	
Phone:	E-mail:

Child Name:	ID Number:	IFSP Meeting Date:

PART V - SERVICE LINKAGES

Service Linkages

Service linkages are community services and supports designed to enhance your child's development and your family's capacity to meet the needs of your child and family. A separate "Service Linkages" form is completed for each family member.

Service linkages are being provided for the following family member. (Check only *ONE* of the following.)

❑ Eligible Child ❑ Sibling ❑ Family ❑ Parent/Guardian ❑ Other Relative

SERVICE LINKAGES TO BE PROVIDED (Check *ALL* that apply.)

Child Care/Enrichment
- ❑ Before/After Child Care
- ❑ Camps, Day/Residential
- ❑ Early Head Start/ Head Start
- ❑ Family Day Care
- ❑ Group Child Care Centers
- ❑ In-home Child Care
- ❑ Preschool Program
- ❑ Tutoring
- ❑ Other______________

Income Assistance
- ❑ Emergency Financial Assistance
- ❑ Financial Counseling
- ❑ Food Stamps
- ❑ Public Assistance
- ❑ SSI
- ❑ Other ______________

Counseling
- ❑ Adolescent
- ❑ Employment
- ❑ Family
- ❑ Genetic
- ❑ Housing
- ❑ Marital
- ❑ Special
- ❑ Other ______________

Medical/Health
- ❑ Assessment
- ❑ Dental Services
- ❑ Diagnostic/Advisory Clinics
- ❑ Equipment/Devices
- ❑ Health Insurance
- ❑ Home Health Care
- ❑ Hospitalization
- ❑ Immunizations
- ❑ Mental Health Services
- ❑ Prenatal Care
- ❑ Prescription Drugs
- ❑ Primary Health Care
- ❑ Screening
- ❑ Substance Abuse Treatment
- ❑ Surgical Procedure
- ❑ Women, Infants, and Children (WIC) Program
- ❑ Other__________________

Other
- ❑ Adult Education
- ❑ Child Care Resource Center, Local
- ❑ Family Support Center
- ❑ Family Support Network, Local
- ❑ Family Support Network, State
- ❑ Home Visiting Program. (Please specify) ______________________
- ❑ Housing
- ❑ Judy Center
- ❑ Legal Services
- ❑ Parent Education
- ❑ Project Independence
- ❑ Recreation Program
- ❑ Support Group
- ❑ Other_________________________

SERVICE LINKAGE PROVIDERS

Provider Name:	Provider Name:
Phone/E-mail:	Phone/E-mail:
Provider Name:	Provider Name:
Phone/E-mail:	Phone/E-mail:

STRATEGIES TO HELP SECURE SERVICE LINKAGES FOR THE FAMILY

PAYMENT SOURCES (Check all that apply.)
- ❑ Health Maintenance Organization (HMO)
- ❑ Medical Assistance
- ❑ No fee
- ❑ Other Health Insurance
- ❑ Parent: Full Payment
- ❑ Parent: Sliding Fee
- ❑ Other: ____

PERSON(S) INVOLVED TO SECURE SERVICE LINKAGES

Name:	Name:
Title:	Title:
Phone:	Phone:
E-mail	E-mail

Child Name:	ID Number:	IFSP Meeting Date:

PART VI - AUTHORIZATION(S)

Authorization(s)

PARENT/GUARDIAN/SURROGATE CONSENT

- I/We have had the opportunity to participate in the development of this Individualized Family Service Plan (IFSP) and have been provided reasonable notice of the IFSP meeting.
- I/We have been informed of my/our parental rights under this program through receipt of the *Parental Rights: Maryland Procedural Safeguards Notice* and a family handbook about Maryland's early intervention system.
- The early intervention services will be provided as described in the IFSP. I/We understand that the IFSP will be reviewed at least every six (6) months.
- I/We understand that my/our consent is voluntary and that I/we may revoke consent at any time.
- I/We understand the records will not be released without my/our signed and written consent except under the provisions of the Family Education Rights and Privacy Act (FERPA). This law allows the release of early intervention records to participating agencies in the early intervention system.
- I/We understand that the public agency will submit information through a statewide database. This database will be used by the Maryland State Department of Education (MSDE) and other State agencies, as appropriate, to enable funding of programs.
- I/We have been informed of the determination(s) of the IFSP team in my/our native language or other mode of communication.
- This plan reflects the outcomes that are important to my/our child and family.
- I/We understand the plan and parental rights and give permission to implement this IFSP.

____

Parent(s)/Guardian/Surrogate Signature *Date*

MEDICAL ASSISTANCE

- I/We choose to accept Service Coordination for Children with Disabilities Case Management. I/we understand that the purpose of this service is to assist in gaining access to needed medical, social, educational, and other services. I/We understand that continuation of this service depends on meeting eligibility requirements for Service Coordination for Children with Disabilities, [COMAR 10.09.40].
- I/We understand that this service does not restrict or otherwise affect a participant's eligibility for other Medical Assistance benefits. I/We understand that I/we am free to choose a case manager/service coordinator for my/our child.
- I/We give permission to the provider agency to recover costs from Medicaid for service coordination, as well as health-related services, related to the implementation of my child's outcomes. I/We understand that if I/we refuse to allow the provider agency access to Medical Assistance funds, it does not relieve the public agency of its responsibility to ensure that all required services are provided to my/our child at no cost to my/our family.

Print Child's Name	*Medical Assistance (MA) Number*
Parent(s)/Guardian/Surrogate Signature	*Date*

Child Name:	ID Number:	IFSP Meeting Date:

PART VII - MY CHILD'S TRANSITION INFORMATION

Section A - Transition At Age Three

Transition At Age 3

TRANSITION PLANNING MEETING DATE: ____

EXPLANATION FOR MEETING DELAY

If the Transition Planning Meeting is **held after the child has reached 33 months of age**, check the response below that provides an explanation. *(Check only one.)*	If the Transition Planning Meeting **was not held at all prior to the child's third birthday**, check the response below that provides an explanation. *(Check only one.)*
❑ Attempts to contact family were unsuccessful.	❑ Attempts to contact family were unsuccessful.
❑ Child was referred at *31.5* months of age or later.	❑ Child was referred at *34.5* months of age or later.
❑ Family requested to reschedule or delay the meeting.	❑ Family declined to participate in the meeting.
❑ Other: ____________________________________	❑ Other: ____________________________________

CONSIDERATION OF ELIGIBILITY FOR PRESCHOOL SPECIAL EDUCATION AND RELATED SERVICES (PART B)

❑ **Parents wish to consider Part B eligibility.** ❑ **Parents DO NOT wish to consider Part B eligibility.**

COMMUNITY SERVICES

Is the family being referred to community services? ❑ Yes ❑ No **If *YES,* check the services that apply.**

Developmental/Medical/Health:

- ❑ Developmental Therapies (other than Part C and Part B)
- ❑ Equipment/Devices
- ❑ Home Health Care
- ❑ Immunizations
- ❑ Mental Health Services
- ❑ Primary Health Care
- ❑ Women, Infants, and Children (WIC) Program

Child Care/Enrichment

- ❑ Camps
- ❑ Family Day Care
- ❑ Group Child Care
- ❑ Even Start
- ❑ Head Start
- ❑ Play Group
- ❑ Preschool Program:
  - __ Public
  - __ Private
- ❑ Recreation Program
- ❑ Judy Center
- ❑ Home Instruction for Parents of Preschool Youngsters (HIPPY)

Family Support

- ❑ Family Support Center
- ❑ Home Visiting Program (Please specify) ______________________________
- ❑ Parent Education
- ❑ Support Group
- ❑ Other: ____________________________

Other Community Services:

____

____

____

TRANSITION PLANNING MEETING NOTES/FUTURE STEPS

Activities	Timelines	Person(s) Responsible

RESULTS OF THE INITIAL IEP ELIGIBILITY DETERMINATION MEETING *(TO BE COMPLETED BY SPECIAL EDUCATION STAFF)*

SPECIAL EDUCATION STAFF: Complete this section and submit to Part C Data Entry **immediately following** the initial IEP eligibility determination meeting. *Check the statement that indicates results of the initial IEP eligibility determination meeting.*

❑ The child is determined to be **ELIGIBLE** for ongoing services through an IFSP *or* preschool special education and related services through an IEP.

❑ The child is determined to be **INELIGIBLE** for ongoing services through an IFSP *or* preschool special education and related services through an IEP.

Child Name:	ID Number:	IFSP Meeting Date:

PART VII - MY CHILD'S TRANSITION INFORMATION

Section B - Transition After Age Three

Transition After Age 3

CONSIDERATION OF SPECIAL EDUCATION AND RELATED SERVICES (PART B)

Prior to Kindergarten Age

- ❑ Parents wish to consider preschool special education and related services through an IEP.
- ❑ Parent **do not** wish to consider preschool special education and related services through an IEP.

At Kindergarten Age

- ❑ Parents wish to consider special education and related services through an IEP.
- ❑ Parent **do not** wish to consider special education and related services through an IEP.

COMMUNITY SERVICES

Is the family being referred to community services? ❑ Yes ❑ No **If *YES,* check the services that apply.**

Developmental/Medical/Health:

- ❑ Developmental Therapies (other than Part C and Part B)
- ❑ Equipment/Devices
- ❑ Home Health Care
- ❑ Immunizations
- ❑ Mental Health Services
- ❑ Primary Health Care
- ❑ Women, Infants, and Children (WIC) Program

Child Care/Enrichment

- ❑ Camps
- ❑ Family Day Care
- ❑ Group Child Care
- ❑ Even Start
- ❑ Head Start
- ❑ Play Group
- ❑ Preschool Program:
  - __ Public
  - __ Private
- ❑ Recreation Program
- ❑ Judy Center
- ❑ Home Instruction for Parents of Preschool Youngsters (HIPPY)

Family Support

- ❑ Family Support Center
- ❑ Home Visiting Program (Please specify) ____________________
- ❑ Parent Education
- ❑ Support Group
- ❑ Other: ____________________

Other Community Services:

____

____

____

MEETING NOTES/FUTURE STEPS

Activities	Timelines	Person(s) Responsible

RESULTS OF IEP ELIGIBILITY DETERMINATION MEETING, IF APPLICABLE *(TO BE COMPLETED BY SPECIAL EDUCATION STAFF)*

SPECIAL EDUCATION STAFF: Complete this section and submit to Part C Data Entry **immediately following** the IEP eligibility determination meeting. *Check the statement that indicates results of the IEP eligibility determination meeting.*

- ❑ The child is determined to be **ELIGIBLE** for special education and related services through an IEP.
- ❑ The child is determined to be **INELIGIBLE** for special education and related services through an IEP.

Child Name:	ID Number:	IFSP Meeting Date:

PART VIII - PARENT CONSENT (*At or Before Age Three)*

Family Choice: Consent to the Continuation or Request Termination of IFSP Services

Families Have A Choice

- I/We have received a copy of the Annual Notification, "*A Family Guide to Next Steps When Your Child In Early Intervention Turns 3 – Families have a choice*."
- I/We have been informed about the differences between the early intervention services provided through an Individualized Family Service Plan (IFSP) under the Individuals with Disabilities Education Act (IDEA) and the preschool special education services provided through an Individualized Education Program (IEP) under IDEA.
- I/We understand my/our child has a current IFSP and that my/our child has been found eligible for preschool special education as a child with a disability under IDEA.
- I/We have been informed of my/our right to choose between the IFSP Option to continue receiving early intervention services through an IFSP or to initiate special education preschool services through an IEP.
- I/We understand that if I/we choose for my/our child to receive services through an IEP and terminate IFSP services, my/our child and family will no longer be eligible through an IFSP.
- I/We understand that if I/we choose for my/our child to receive services through an IFSP, at any time I/we may terminate participation in early intervention services through an IFSP and choose to initiate special education preschool services through an IEP.
- I/We understand that the local lead agency is required to continue to provide IFSP services under the Extended IFSP Option until the date on which services through an IEP are initiated. However if, I/we choose the IEP option but refuse to consent to the special education and related services offered in the IEP developed by the IEP team, I/we understand IFSP services will be terminated.
- I/We understand that my/our consent to the continuation of IFSP services is voluntary and that I/we may revoke consent at any time.

FAMILY CHOICE

Check ONE box.

- ☐ I/We consent to the **continuation** of early intervention services for my/our child and family through an IFSP after my/our child's third birthday.
- ☐ I/We request **termination** of early intervention services for my/our child and family through an IFSP at age 3.

____

Parent(s)/Guardian/Surrogate Signature *Date*

____

Service Coordinator *Date*

____

Other Participant *Agency/Title* *Date*

____

Other Participant *Agency/Title* *Date*

Child Name:	ID Number:	IFSP Meeting Date:

Individualized Family Service Plan (IFSP)
ADD/CHANGE FORM

IFSP Review

CHANGES TO CHILD AND FAMILY INFORMATION

(Changes to demographic information do NOT require a parent signature.)

Child Information:

Child's Name:______________________________

Address:______________________________

____

Phone: ______________________________

Birthdate: ______________________________

Medical Assistance #:______________________________

Family Information:

Name:______________________________

Address:______________________________

____

Phone: ______________________________

E-mail: ______________________________

Relationship to Child:______________________________

Service Coordinator Information:

Name:______________________________

Agency:______________________________

Phone: ______________________________

E-mail: ______________________________

REVIEW OF THE IFSP

Review Type: Select ***one***.

Meeting Date: ______________________________

- ❏ Six Month
- ❏ Annual
- ❏ Provider Request
- ❏ Parent Request
- ❏ Parent/Provider Request

Review Status: Select ***one***.

- ❏ Continue IFSP
- ❏ Modify IFSP
  - ☐ Service Addition
  - ☐ Service Modification
  - ☐ Service Ending
  - ☐ Add/Modify Outcomes
- ❏ End IFSP *(If selected, complete the "Reason for Inactive Status" section below.)*

Reasons for Inactive Status: Select ***one***.

Inactive Date: ______________________________

- ❏ Attempts to contact unsuccessful (*Birth to Kindergarten Age*)
- ❏ Completion of IFSP prior to reaching age 3 (*Birth to 3)*
- ❏ Deceased (*Birth to Kindergarten Age*)
- ❏ Determined ineligible (***Note:*** This child was never eligible.) (*Birth to 3*)
- ❏ Moved out of state (*Birth to Kindergarten Age*)
- ❏ Moved to another jurisdiction (*Birth to Kindergarten Age)*
  Name of Jurisdiction: ______________________________
- ❏ Parent withdrawal (*Birth to Kindergarten Age)*
- ❏ Transition at age 3 (Not Continuing on an IFSP) (*Birth to 3)*
- ❏ Completion of IFSP prior to reaching Kindergarten Age (*Age 3 to Kindergarten Age*)
- ❏ Transition after age 3 (*Age 3 to Kindergarten Age*)

I/We have been provided with reasonable notice of the review of this IFSP. I/We have had the opportunity to participate in the review of this IFSP. I/We have been informed of my/our parental rights through the *Parental Rights: Maryland Procedural Safeguards Notice* and give permission to the early intervention program to implement any IFSP revisions based on this review.

____
Parent(s)/Guardian/Surrogate Signature *Date*

____
Service Coordinator *Date*

____
Other Participant *Agency/Title* *Date*

____
Other Participant *Agency/Title* *Date*