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| Ifsp DocNorth Carolina Infant-Toddler Program Individualized Family Service Plan |

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| **Child's Name:**       | **Gender:**  |
| **Date of Birth:**       | **Date of Referral:**  |
| **IFSP Type & Date:**  | **IFSP Signature Date:**  |
| **Parent Name:**       | **Parent Name:**       |
| **Parent Email:**       | **Parent Email:**       |
| **Parent Phone:**       | **Parent Phone:**       |
| **Language of Parent:**  | **Language of Child:**  |
| **Child's Address:**       | **County:**       |
| **LEA/PSU:**      **Date LEA/PSU Notification Sent:**  | **Service Coordinator:**  |

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| I. IFSP TEAM(Add name/Role/Contact info for each team member)      |

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| II. FAMILY'S CONCERNS, PRIORITIES, AND RESOURCESYour 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. |
| **Date Family Assessment Completed:**      **Participants/Team Members:**      **Name of Family-directed Assessment Tools:**      **Family's Area of Concern:**      **Family Priorities:**      **Strengths and Resources that Assist in Meeting the Needs of your Child and Family:**      **Additional Information:**       |

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| III. CHILD'S PRESENT SKILLS AND ABILITIESThis section of the IFSP provides a picture of your child's strengths and needs, the people, places and things that interest and motivate your child, and his/her likes and dislikes. The Children Developmental Services Agency (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 that your child has developed so far and how your child combines and uses these skills and behaviors to participate in daily activities. |
| **Evaluation/Assessment Date:**  | **Evaluation Instruments:**       |
| **Evaluator(s):**       | **Assessment Method:**       |
| **Chronological Age of Child at Evaluation:**       | **Adjusted Age:**       |
| **Individuals Present (List Interpreter, if present):**       |
| **CHILD HEALTH INFORMATION SUMMARY:** Summary of child's health status based on review of pertinent records and/or parent report which may include, child's birth history, medical conditions or diagnoses, illnesses, hospitalizations, medications, vision and hearing status, or other information.       |
| **Developmental Delay: Select Y/N** | **Established Condition:** **Select Y/N** |
| **Informed Clinical Opinion:Select Y/N** | **Est. Condition Subcategory:Select from list** |
| **Any additional information about your child's development that is important in planning and providing supports for your child and family.** |       |

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| Summary of Test Results |
| **Developmental Area** | **Standard Score** |
| **Communication/Language (Receptive & Expressive)** | **Combined:**      **Expressive:**  **Receptive:**       |
| **Cognitive/Early Learning** |       |
| **Physical Development (Gross Motor & Fine Motor)** | **Combined:**      **Gross:**      **Fine:**       |
| **Social-Emotional** |       |
| **Adaptive/Self-Help** |       |

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| **Child Developmental Outcomes - Initial** **Child Outcome Summary (COS) Date Completed:**  | **Things Your Child Can Do** | **Next Steps** |
| Positive social-emotional skills (including social relationships) (relating to adults and other children, showing emotions and feelings appropriately for age, cooperating in daily routines)  |       |       |
| Where are your child's skills and behaviors now? | Choose an item. |
| Acquiring and using knowledge and skills (thinking and problem-solving through play, communicating, developing interest in books) |       |       |
| Where are your child's skills and behaviors now? | Choose an item. |
| Taking appropriate action to meet needs(learning to take care of self, using hands and fingers in play and daily living activities, moving around independently, using language to express wants and needs) |       |       |
| Where are your child's skills and behaviors now? | Choose an item. |

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| **Child Developmental Outcomes Ongoing****Child Outcome Summary (COS) Date Completed:**  | **Things Your Child Can Do** | **Next Steps** |
| Positive social-emotional skills (including social relationships)(relating to adults and other children, showing emotions and feelings appropriately for age, cooperating in daily routines) |       |       |
| Acquiring and using knowledge and skills(thinking and problem-solving through play, communicating, developing interest in books)  |       |       |
| Taking appropriate action to meet needs(learning to take care of self, using hands and fingers in play and daily living activities, moving around independently, using language to express wants and needs)  |       |       |

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| **Child Developmental Outcomes Exit****Child Outcome Summary (COS) Date Completed:**  | **Things Your Child Can Do**  | **Next Steps** |
| Positive social-emotional skills (including social relationships)(relating to adults and other children, showing emotions and feelings appropriately for age, cooperating in daily routines) |       |       |
| Where are your child's skills and behaviors now? | Choose an item. |
| Has the child shown any new skills or behaviors related to acquiring and using knowledge and skills since the last outcomes summary?**Select Y/N** |       |
| Acquiring and using knowledge and skills(thinking and problem-solving through play, communicating, developing interest in books)  |       |       |
| Where are your child's skills and behaviors now? | Choose an item. |
| Has the child shown any new skills or behaviors related to positive socio-emotional skills (including positive social relationships) since the last outcomes summary? **Select Y/N** |        |
| Taking appropriate action to meet needs(learning to take care of self, using hands and fingers in play and daily living activities, moving around independently, using language to express wants and needs)  |       |       |
| Where are your child's skills and behaviors now? | Choose an item. |
| Has the child shown any new skills or behaviors related to taking appropriate action to meet needs since the last outcomes summary? **Select Y/N** |       |

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| Specialty AssessmentThis 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. |
| **Evaluation/Assessment Description:**  |
| **Evaluator Name and Discipline:**  |
| **Summary:**  |
| **Evaluation/Assessment Description:**  |
| **Evaluator Name and Discipline:**  |
| **Summary:**  |

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| **IV. IFSP OUTCOMES** Outcomes must be measurable and reflect changes the family would like to see happen for themselves and their child.  |
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| **Outcome#:**  | **Target:** Choose an item. | **Target Date:**  |

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| **Outcome Description** (What would you and your family like to see happen for your child/family in the next six months?):       |
| **Strategies and Activities** (What are the ways in which your family and team will work toward achieving this outcome? Who will help and what will they do?)       |
| **What's happening now?** (What's happening now related to this outcome?)       |
| **Criteria for Progress** (How will we know we've made progress or if revisions are needed to the outcomes, strategies, or services?)       |
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| **Start Date:**  | **Date Reviewed:**  | **Outcome Status:**  |

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| **Outcome Review:**  |
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| **Outcome#:**  | **Target:** Choose an item. | **Target Date:**  |

 |
| **Outcome Description** (What would you and your family like to see happen for your child/family in the next six months?):       |
| **Strategies and Activities** (What are the ways in which your family and team will work toward achieving this outcome? Who will help and what will they do?)       |
| **What's happening now?** (What's happening now related to this outcome?)       |
| **Criteria for Progress** (How will we know we've made progress or if revisions are needed to the outcomes, strategies, or services?)       |
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| **Start Date:**  | **Date Reviewed:**  | **Outcome Status:**  |

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| **Outcome Review:**  |
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| **Outcome#:**  | **Target:** Choose an item. | **Target Date:**  |

 |
| **Outcome Description** (What would you and your family like to see happen for your child/family in the next six months?):       |
| **Strategies and Activities** (What are the ways in which your family and team will work toward achieving this outcome? Who will help and what will they do?)       |
| **What's happening now?** (What's happening now related to this outcome?)       |
| Criteria for Progress (How will we know we've made progress or if revisions are needed to the outcomes, strategies, or services?)       |
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| **Start Date:**  | **Date Reviewed:**  | **Outcome Status:**  |

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| **Outcome Review:**  |

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| **V. IFSP SERVICE DELIVERY PLAN** |
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| **Service** | **Provider** | **Projected Start Date** | **Actual Start Date** | **Setting** | **Frequency/ Length/ Intensity/ Method** | **Payor(s)** | **Current Authorization Period** | **Justifications for environment** |
|       |        |       |       |       |       |       |       |        |
|       |        |       |       |       |       |       |       |        |
|       |        |       |       |       |       |       |       |        |
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| Other Services(Add Service/Provider/Start Date/End Date)      |

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| VII. TRANSITION PLANNING |
| **Transition Plan 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)  |       |       | Started:       Completed:       |
| 2. 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.  |       |       | Started:       Completed:      |
| 3. Discussion of Child Find purpose and process.  |       |       | Started:       Completed:      |
| 4. Send specified information to Part B if parental consent is provided.   |       |  | Started:       Completed:      |
| 5. 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)  |       |       | Started:       Completed:      |
| 6. 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. |       |  | Started:       Completed:       |

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| IFSP Meeting Note      |

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| **VIII. IFSP Agreement** |
| **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.** |       |
|  |       |
| **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)*  |
|       |  |       |
| Parent/Guardian Signature and Date |  | Parent/Guardian Signature and Date |
|       |  |       |
| EI Service Coordinator Signature and Date |  | Agency Representative or Designee Signature/Agency and Date |
|       |  |       |
| Other Signature and Date |  | Other Signature and Date |

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| IX. IFSP Review |
| **Review Date**       |  |
|       |
| 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** |
|       | 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.**  |       |
|       |
| **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. |
|       |  |       |
| Parent/Guardian Signature and Date |  | Parent/Guardian Signature and Date |
|       |  |       |
| EI Service Coordinator Signature/ and Date |  | Agency Representative or Designee Signature/Agency and Date |
|       |  |       |
| Other Signature and Date |  | Other Signature and Date |

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