# Infant & Toddler Connection of Virginia

## Individualized Family Service Plan (IFSP)

**Local System Name Here**

## I. Child and Family Information

**Child's Name:** _____ **Date of Birth:** _____

**Gender:** ☐M ☐F **Child's County or City of Residence:** _____

**IFSP Date:** _____ ☐ **Initial** ☐ **Annual** # _____ **Date 6 mo. Review Due:** _____

**Date(s) Review(s) Completed:** _____

**Family's Primary Language and/or Mode of Communication:** _____ **Child's** *(if different)* _____

**Medicaid Number (optional):** _____

**Parent's and/or Other Family Member's Name, Address, Phone And Other Contacts:**

**Service Coordinator's Name, Agency, Address, Phone Number, Email and Fax Number:**

Early Intervention services are provided to eligible children and their families in compliance with Part C of the federal *Individuals with Disabilities Education Act.*

## IIa. Child and Family Activities

*(What we want the people helping us to know about our everyday routines and activities: places we go or would like to go, people we are with or would like to be with, activities we do or would like to do, and activities our child enjoys.)*

## IIb. Family Identified Resources, Priorities, & Concerns

*(What we want the people helping us to know about the resources and supports we have and the concerns and priorities we have about our child's development.)*

**Voluntary!**
Your child can still receive services if you do not complete section IIb.

_____ *Parent initial if choosing not to provide this information.*
_____ *Parent initial if choosing not to include this information in the IFSP.*

## III. Team Assessment Narrative

Include the referral source and reason for referral, any medical diagnoses (especially those related to the reason for referral), pertinent health and physical development information (including pertinent medical history, clinical signs and symptoms, current health status), a statement of child's present levels of development in all areas of development, vision and hearing screening results, and a summary of functional strengths and limitations.

**The following people participated in the assessment for service planning** (*Printed name, credentials, signature, date*):

Parent

Service Coordinator

Discipline: ☐Educator/Special Educator ☐Occupational Therapist ☐Physical Therapist ☐Speech-Language Pathologist ☐Nurse ☐Other

Discipline: ☐Educator/Special Educator ☐Occupational Therapist ☐Physical Therapist ☐Speech-Language Pathologist ☐Nurse ☐Other

Discipline: ☐Educator/Special Educator ☐Occupational Therapist ☐Physical Therapist ☐Speech-Language Pathologist ☐Nurse ☐Other

Discipline: ☐Educator/Special Educator ☐Occupational Therapist ☐Physical Therapist ☐Speech-Language Pathologist ☐Nurse ☐Other

**Information from the following assessments completed outside the Infant & Toddler Connection of Virginia system was used to complete the assessment for service planning** (*Printed name, credentials, discipline, organization*):

## III. Team Assessment Narrative

## IV. Outcomes of Early Intervention

**Outcome** (Long-Term Goal) **# 1 – Service Coordination** (required)
In order to help your child and family receive the supports and services you need, your service coordinator will assure:

- that the IFSP addresses your identified concerns, priorities and resources;
- the appropriateness and adequacy of supports and services;
- your satisfaction with supports and services; and
- that your child's and family's rights are protected.

| Short-Term Goals | Target Date | Date Met |
|---|---|---|
| Assist your family with the development and ongoing review and revision of the IFSP. | ongoing | |
| Provide support and assistance to your family in addressing issues or concerns that emerge over time. | ongoing | |
| Provide information and support your family, as needed, in accessing routine medical care for your child. | ongoing | |
| Provide supports identified by your family to include resources for: | | |
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**Service Coordination Activities** *(Interventions)*:

- Maintain ongoing contact with you for service monitoring
- Phone calls/personal contacts with your family and with individuals/agencies that provide support, assistance, services.
- Link your family with appropriate community resources.
- Assist with problem solving.

## IV. Outcomes of Early Intervention

**Date Outcome Added:** _____

**Acquisition:** Describe skill or behavior child or family is to acquire or achieve.
**Context or Setting within Everyday Routines and Activities:** Identify child's or family's everyday routine/activity in which the behavior is expected.
**Criterion for Achievement Over What Amount of Time:** Describe frequency/duration/rate for the new skill/behavior stated over a specific time period.

**Outcome** (Long-Term Functional Goal) **#** **Target Date:** **Date met, changed or ended:**

**Learning opportunities and activities that build on child's and family's interests and abilities:**

| **Short-Term Goals** | **Target Date** | **Date Met** |
|---|---|---|
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**Interventions (Treatment procedures and/or modalities)**

## V. Services Needed to Achieve Early Intervention Outcomes

| ENTITLED SERVICE | FREQUENCY (# x/wk/ month/once) | LENGTH (# min/visit) | GROUP (G) / INDIVIDUAL (I) | METHODS** (a,b,c,d) | NATURAL ENVIRONMENT/ LOCATION (Must be a natural setting unless justified below) | PAYMENT 1 Family Fee 2 Insurance 3 Medicaid 4. State Funds 5. Local Funds 6. Part C | PROJECTED START DATE | PROJECTED END DATE | ACTUAL END DATE |
|---|---|---|---|---|---|---|---|---|---|
| **1. Service Coordination** | | | | Service coordination | | | | | |
| **2.** | | | | | | | | | |
| **3.** | | | | | | | | | |
| **4.** | | | | | | | | | |
| **5.** | | | | | | | | | |
| **6.** | | | | | | | | | |
| **7.** | | | | | | | | | |
| **8.** | | | | | | | | | |

* This is the minimum frequency and length of direct contact from your service coordinator. The frequency and length of service coordination actually provided will vary since service coordination is an active, ongoing process that changes based on your family's priorities and needs.

** Methods: a = Coaching, including hands-on as appropriate b = Consultation c = Assessment
d = Provision of assistive technology device

| **Justification of why early intervention outcomes can't be achieved satisfactorily in a natural setting <u>and</u> a plan with timelines and supports necessary to return early intervention services to natural settings:** |
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| **Reason for later projected start date - For each service that is planned to start more than 30 calendar days after the family signs the IFSP, indicate whether the reason is family scheduling preference, team planned a later start date to meet child and family needs, or other:** |
|---|
| |

## VI. Other Services *(Services needed, but not entitled under Part C - including medical services such as well baby checks, follow-up with specialists for medical purposes, etc.)*

| SERVICE | PROVIDER | LOCATION | STEPS TO BE TAKEN TO ASSIST IN SECURING SERVICES |
|---|---|---|---|
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# VII. Transition Planning

**The following information about transition is discussed beginning at the initial IFSP meeting**:

- Transition happens when your child leaves early intervention. The planning on this page will help you and your child move smoothly from early intervention to whatever comes next for your child.
- Options after early intervention (examples: community programs like neighborhood nursery schools, Head Start, early childhood special education through the public schools).
- Possible timing of transition
  - When your child reaches age level in all developmental areas and meets no other eligibility requirements for early intervention
  - When your child reaches his/her third birthday, which is the end of eligibility for early intervention
  - When and if your child begins early childhood special education services through the public schools (between age 2 and 3), if you are interested in those services. Children may not be served in early intervention and early childhood special education through the public schools at the same time.

This information was discussed on _____ (date) by _____ (initials of service coordinator)

**Important Dates for Transition Planning:**

_____ - target date for notification and referral to determine eligibility if you are interested in early childhood special education services through your local school system (referral must occur at least 90 days before the anticipated date of transition and must occur by April 1 of the year your child turns 2 by Sept. 30 if you want your child to begin school on the first day of the next school year).

_____ (date of child's 3rd birthday) – date on which your child is no longer eligible to receive early intervention

## Transition Plan

The transition activities completed will depend on your transition plans and family preferences.

| Transition Steps/Activities | Target Date | Date Completed | Initials Person Completing |
|---|---|---|---|
| 1. **Community Options**: Help your family explore community program options, which may include early childhood special education services, for your child<br>a. Provide information, including program contact information, about community options following early intervention, as desired by your family. Information provided on the following programs: _____<br>b. Arrange for visits to programs, as desired by your family. Programs visited: _____<br>c. Other steps/activities (e.g., if you are interested, provide names of other families, with their permission, who have transitioned to programs you are considering): _____ | | | |
| 2. **Notification and Referral to the Local School Division and Virginia Department of Education**: At least 90 days before the anticipated date of transition and before April 1 of the year your child turns 2 by Sept. 30 if you want your child to begin school on the first day of the next school year –<br>a. Send your child's name, date of birth and your contact information (name, address, phone number) to the _____ school division and Virginia Department of Education no earlier than _____ unless you disagree. Sending this information helps the school system to know who in the community may be eligible for special education services and is a referral to the local school division.<br>• I do not want my child's name, date of birth and our contact information sent to the local school division and Virginia Department of Education for notification and referral _____ (parent initials and date)<br>• I have changed my mind and agree to have this information sent to the local school division and Virginia Department of Education _____ (parent initials and date)<br>b. Date notification and referral sent _____<br>c. With your consent on a release of information form, send specific information about your child to the local school division (e.g., most recent eligibility determination and assessment reports, IFSP, etc.).<br>• Your consent obtained on release of information form on _____ (date)<br>• Date information sent _____ | | | |

**Child's Name:** _____

**IFSP Date:** _____ **DOB:** _____

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| Transition Steps/Activities | Target Date | Date Completed | Initials Person Completing |
|---|---|---|---|
| 3. **Support to Enroll in Other Programs**: Help your family enroll in a community program(s), other than the local school division, that you are interested in for your child, as available.<br>a. Help with getting and filling out paperwork and/or completing other steps necessary to enroll in the desired program: _____<br>b. If needed, with your consent on a release of information form, refer your child and send specific information about your child to the future service provider or program (e.g., most recent eligibility determination and assessment reports, IFSP, etc.)<br>• Your consent obtained on release of information form on _____ (date)<br>• Referral sent to _____ (program) on _____ (date)<br>• Date information sent: _____<br>c. Other steps/activities: _____ | | | |
| 4. **Transition Planning Conference**: At least 90 days, and up to 9 months if everyone agrees, before your child's anticipated date of transition –<br>If your family is considering transition to early childhood special education services, hold a transition conference between you, your service coordinator, and someone from the new program to plan how to make the transition.<br>a. *Parental Prior Notice* form provided on _____ (date)<br>b. You ☐ approve/ ☐ do not approve conference.<br>c. Service Coordinator ensures scheduling of conference and participation by required parties:<br>• Transition conference held on _____ (date)<br>• The following participated: ☐ (You - required), ☐ (early intervention- required), ☐ (school division - required), ☐ (other _____), ☐ (other _____) | | | |
| 5. **Transition Services**: Once your transition plans have been determined, help your child and family prepare, as desired by your family, for changes in supports and services so you can move smoothly out of early intervention and, if appropriate, into a new program<br>a. Your child will transition to _____ on _____ (projected date)<br>b. Help your child and family get ready to transition out of early intervention and, if appropriate, into a new program/setting by:<br>_____ | | | |
| 6. **Exiting Early Intervention**: Discharge your child from the local Part C system before his/her 3rd birthday<br>a. *Parental Prior Notice* form is signed ☐Yes ☐No<br>b. If child is on inactive status: *Parental Prior Notice* form sent on _____ (date)<br>*Parental Prior Notice* form is signed ☐Yes ☐No<br>c. Date of discharge/closure _____ | | | |

# VIII. IFSP AGREEMENT

## Parental Consent for Provision of Early Intervention Services:

I have received a copy of family rights and information about family cost share under Part C of IDEA (*Notice of Child and Family Rights and Safeguards Including Facts about Family Cost Share*) along with this IFSP. These rights and payment policies have been explained to me and I understand them. I participated in the development of this IFSP and I give informed consent for the Infant & Toddler Connection of Virginia system and service providers to carry out the activity(ies) listed on this IFSP.

Consent means I have been fully informed of all information about the activity(ies) for which consent is sought, in my native language (unless clearly not feasible to do so) or other mode of communication; that I understand and agree in writing to the carrying out of the activity(ies) for which consent is sought; the consent describes that activity(ies); and the granting of 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) my child or family receive through the Infant & Toddler Connection of Virginia system.

I understand that my IFSP will be shared within the local Infant & Toddler Connection of Virginia system, including with providers involved in assessment and/or in the development and/or implementation of this IFSP.

_____ _____

Signature(s) of *(check one)*: ☐Parent(s) ☐Legal Guardian ☐ Surrogate Parent — Date

**Other IFSP Participants** (*Printed name, credentials, signature, date*):

Discipline: Service Coordinator

Discipline: ☐Educator/Special Educator ☐Occupational Therapist ☐Physical Therapist ☐Speech-Language Pathologist ☐Nurse ☐Other

Discipline: ☐Educator/Special Educator ☐Occupational Therapist ☐Physical Therapist ☐Speech-Language Pathologist ☐Nurse ☐Other

Discipline: ☐Educator/Special Educator ☐Occupational Therapist ☐Physical Therapist ☐Speech-Language Pathologist ☐Nurse ☐Other

Discipline: ☐Educator/Special Educator ☐Occupational Therapist ☐Physical Therapist ☐Speech-Language Pathologist ☐Nurse ☐Other

**The following individuals participated electronically or in writing** (*specify which*):

**Translator/Interpreter** (*if used*):

**The following related documents are attached:**

**Copies to:**

**Physician Certification (required in order to bill insurance):** I certify and approve that services, as described in the IFSP, are medically necessary for this child.

*Signature* *Credentials* *Date*

## IX. IFSP Review Record

**Purpose of Review:** ☐ 6 month Review ☐ Upon Request by: _____ Review Date: _____

**Summary** (*Include rationale for any changes resulting from this review*)*:*

**Change(s):** **Projected Start Date For Change:**

### Parental Consent

I have received a copy of family rights and information about family cost share under Part C of IDEA (*Notice of Child and Family Rights and Safeguards Including Facts about Family Cost Share*) along with this IFSP Review Record. These rights and payment policies have been explained to me and I understand them. I participated in the development of this IFSP Review and I give informed consent for Infant & Toddler Connection of Virginia system and service providers to carry out any changes listed on this IFSP Review Record.

Consent means I have been fully informed of all information about the activity(ies) for which consent is sought, in my native language (unless clearly not feasible to do so) or other mode of communication; that I understand and agree in writing to the carrying out of the activity(ies) for which consent is sought; the consent describes that activity(ies); and the granting of 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) my child or family receives through the Infant & Toddler Connection of Virginia system.

I understand that my IFSP will be shared within the local Infant & Toddler Connection system, including with providers involved in assessment and/or development and/or implementation of this IFSP.

_____ _____

Signature(s) of *(check one)*: ☐Parent(s) ☐Legal Guardian ☐ Surrogate Parent Date

**Child's Name:** _____

**IFSP Date:** _____ **DOB:** _____

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## If services increased on this IFSP review and my child is covered by private insurance:

☐ My insurance should be billed for covered services. Unless my monthly cap is $0, I agree to continue paying for any applicable co-payments, deductibles and/or non-covered services in the manner indicated in the Charges section on the Family Cost Share Agreement form. I understand I can cancel this consent at any time by giving written notice to my child's service coordinator.

☐ My insurance should no longer be billed for covered services. Unless my monthly cap is $0, I agree to pay for services in the manner indicated in the Charges section on the Family Cost Share Agreement form. I understand that I must complete and sign a new Family Cost Share Agreement form.

I understand I can contact my service coordinator if I have questions about use of insurance or the payment arrangements on the Family Cost Share Agreement form.

Signature(s) of *(check one)*: ☐Parent(s) ☐Legal Guardian ☐ Surrogate Parent Date

**Other IFSP Participants** (*printed name, credentials, signature, date*)**:**

Discipline: Service Coordinator

Discipline: ☐Educator/Special Educator ☐Occupational Therapist ☐Physical Therapist ☐Speech-Language Pathologist ☐Nurse ☐Other

Discipline: ☐Educator/Special Educator ☐Occupational Therapist ☐Physical Therapist ☐Speech-Language Pathologist ☐Nurse ☐Other

Discipline: ☐Educator/Special Educator ☐Occupational Therapist ☐Physical Therapist ☐Speech-Language Pathologist ☐Nurse ☐Other

**The following individuals participated electronically or in writing** (*specify which*):

**Physician Certification (required in order to bill insurance):** I certify and approve that _____ services, as described in the IFSP, are medically necessary for this child.

*Signature* *Credentials* *Date*

**Child's Name:** _____

**IFSP Date:** _____ **DOB:** _____

**Infant & Toddler Connection of Virginia**

## Addendum

*(Refer to corresponding number on page 6 of the IFSP for service details)*

| # | Service | SERVICE PROVIDER *(Name, agency, address, phone number)* | Current? |
|---|---|---|---|
| 1 | Service Coordination | | ☐ N |
| | | | ☐ N |
| | | | ☐ N |
| 2 | | | ☐ N |
| | | | ☐ N |
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| 8 | | | ☐ N |
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| | | | ☐ N |

I was given the opportunity to choose from among provider agencies who work in my local system area and who are in my payor network. I may request to change service providers at any time by contacting my service coordinator.

For Services # _____ Signature(s) of *(check one)*: ☐Parent(s) ☐Legal Guardian ☐ Surrogate Parent _____ Date

For Services # _____ Signature(s) of *(check one)*: ☐Parent(s) ☐Legal Guardian ☐ Surrogate Parent _____ Date

For Services # _____ Signature(s) of *(check one)*: ☐Parent(s) ☐Legal Guardian ☐ Surrogate Parent _____ Date