



**INDIANA'S INDIVIDUALIZED FAMILY SERVICE PLAN
TO ENHANCE THE CAPACITY OF FAMILIES TO MEET
THE SPECIAL NEEDS OF THEIR CHILD**

State Form 46514 (R10 / 10-06) / BCD 0001



IFSP		
Initial date (month, day, year)	Annual effective date (month, day, year)	County

SECTION 1: IDENTIFYING INFORMATION

Name of child (last, first, middle initial) *		A.K.A. name	
Social Security number **	Date of birth (month, day, year) *	Chronological / adjusted age *	Gender *
First Steps identification number *			
Family's primary language / mode of communication			
Child's primary language / mode of communication *			
Type of representative (check one): *			
<input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Foster parent <input type="checkbox"/> Surrogate parent			
Name of representative(s) *			
Address (number and street) *			
City *		ZIP code *	County *
, IN			
Work telephone number *		Home telephone number *	
()		()	
Cellular telephone number *		Email address	
()			

OTHER CONTACT INFORMATION

Name(s) of other contacts			
Address (number and street)			
City *		ZIP code	County
, IN			
Work telephone number *		Home telephone number *	
()		()	
Cellular telephone number *		Email address	
()			

SECTION 2: SERVICE COORDINATION INFORMATION

Name of service coordinator *		Name of agency *	
Telephone number(s) *		Fax number *	
()		()	
Address (number and street) *			Email address
City *		ZIP code *	
, IN			
Name of intake coordinator		Telephone number	
		()	
Fax number		Email address	
()			
Address (number and street)			
City *		ZIP code *	
, IN			

* Denotes part of the electronic record.

** Your child's Social Security number is requested in order to expedite processing this IFSP. Disclosure is voluntary and you will not be penalized for refusal per I.C. 4-1-8-1.

Name of child	Date of birth (month, day, year)	IFSP date (month, day, year)
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SECTION 3: SUMMARY OF CHILD'S PRESENT LEVEL OF PERFORMANCE & EVALUATION INFORMATION

Please document the requested information below. All information should relate to the developmental needs of the child and family and should be gathered from discussion with the family.

List child / family strengths:

Concerns / needs related to the child's development:

Medical diagnosis / health status:

Screening results:

Vision: Passed Concerns
Comments:

Screening results:

Hearing: Passed Concerns
Comments:

Please document information relating to the child's development. Information may be gleaned from assessments, structured observation or other methods. **Parent report must be utilized.** The statement about the child's present level of performance must be based on professionally acceptable objective criteria. This information is then to be utilized in the determination of eligibility.

DOMAIN (Person / Date)	ASSESSMENT PROCEDURES Please check all procedures used	STATEMENT OF CHILD'S CURRENT LEVEL OF PERFORMANCE <input type="checkbox"/> Child in NICU Describe the child's current level of performance. In addition, provide Raw score <u>and</u> Standard Deviation. Check if services are recommended.	
Physical ** Development Date (mo., day., yr.)	<input type="checkbox"/> Structured observation <input type="checkbox"/> State approved assess.* <input type="checkbox"/> Other assessment <input type="checkbox"/> Parent report (required)	Fine Motor: Raw Score _____ Deviation _____ Services recommended: <input type="checkbox"/> Yes <input type="checkbox"/> No	Gross Motor: Raw Score _____ Deviation _____ Evaluation recommended: <input type="checkbox"/> Yes <input type="checkbox"/> No
Adaptive Date (mo., day., yr.)	<input type="checkbox"/> Structured observation <input type="checkbox"/> State approved assess.* <input type="checkbox"/> Other assessment <input type="checkbox"/> Parent report (required)	Raw Score _____ Deviation _____ Services recommended: <input type="checkbox"/> Yes <input type="checkbox"/> No	Evaluation recommended: <input type="checkbox"/> Yes <input type="checkbox"/> No
Cognitive Date (mo., day., yr.)	<input type="checkbox"/> Structured observation <input type="checkbox"/> State approved assess.* <input type="checkbox"/> Other assessment <input type="checkbox"/> Parent report (required)	Raw Score _____ Deviation _____ Services recommended: <input type="checkbox"/> Yes <input type="checkbox"/> No	Evaluation recommended: <input type="checkbox"/> Yes <input type="checkbox"/> No
Communication Date (mo., day., yr.)	<input type="checkbox"/> Structured observation <input type="checkbox"/> State approved assess.* <input type="checkbox"/> Other assessment <input type="checkbox"/> Parent report (required)	Raw Score _____ Deviation _____ Services recommended: <input type="checkbox"/> Yes <input type="checkbox"/> No	Evaluation recommended: <input type="checkbox"/> Yes <input type="checkbox"/> No
Social Date (mo., day., yr.)	<input type="checkbox"/> Structured observation <input type="checkbox"/> State approved assess.* <input type="checkbox"/> Other assessment <input type="checkbox"/> Parent report (required)	Raw Score _____ Deviation _____ Services recommended: <input type="checkbox"/> Yes <input type="checkbox"/> No	Evaluation recommended: <input type="checkbox"/> Yes <input type="checkbox"/> No

* State approved assessment: Assessment, Evaluation, and Programming System for Infants and Children (AEPS) Second Edition.

** Physical Development is defined as motor skills, vision and hearing.

Name of child	Date of birth (month, day, year)	IFSP date (month, day, year)
SECTION 5: SERVICE COORDINATION WORKSHEET / OUTCOME		
<p>Service Coordinator role: To provide service coordination services that assist and enable an infant or toddler and the child's family to receive the services, rights and procedural safeguards authorized to be provided under the early intervention program. Service coordination involves assisting parents in gaining access to early intervention services, coordinating the provision of early intervention services and other services the child needs, facilitating parent to parent support services, facilitating the timely delivery of available services, and continuously seeking the appropriate services and situation necessary to benefit the development of the child for the duration of the child's eligibility.</p>		
RESPONSIBILITIES:		
ASSESSMENT OF CLIENT NEEDS:		
<input type="checkbox"/> Complete family interview / exit summary		Date (month, day, year)
<input type="checkbox"/> Arrange for additional evaluations, assessments, health screenings, etc. _____		Date (month, day, year)
<input type="checkbox"/> Other activities: _____		Date (month, day, year)
COORDINATION / ADVOCACY:		
<input type="checkbox"/> Assist family in locating community resources/parent supports: _____		Date (month, day, year)
<input type="checkbox"/> Coordinate services/communications with other service providers: _____		Date (month, day, year)
<input type="checkbox"/> Coordinate services/communications with primary medical provider: _____		Date (month, day, year)
<input type="checkbox"/> Facilitate referrals to other programs (i.e., Medicaid Waiver, SSI, etc.) _____		Date (month, day, year)
MONITORING OF IFSP:		
<input type="checkbox"/> Contact family/providers regarding progress toward outcomes as written in IFSP as follows: Preferred method of contact (i.e., face-face, email, phone, etc.) _____ Preferred frequency of contact: (i.e., monthly, quarterly, etc.) _____		
<input type="checkbox"/> Receive and disseminate quarterly progress reports: _____		
<input type="checkbox"/> Coordinate and plan for 6 month review of IFSP by: _____		Date (month, day, year)
<input type="checkbox"/> Facilitate recommended changes to IFSP, including AT requests _____		
<input type="checkbox"/> Maintain/review EI file at SPOE: _____		
EVALUATION OF IFSP		
<input type="checkbox"/> Additional evaluations needed to determine annual eligibility: _____		
<input type="checkbox"/> Meet with family to discuss family concerns, priorities, and resources prior to annual IFSP: _____		
<input type="checkbox"/> Coordinate and plan for annual IFSP by: _____		
<input type="checkbox"/> Complete Family Update form, including cost participation activities: _____		
FINANCIAL CASE MANAGEMENT		
<input type="checkbox"/> Review and update Private Medical Health Insurance form: _____		
<input type="checkbox"/> Follow-up or complete CSHCS/Hoosier Healthwise application: _____		

Name of child	Date of birth (month, day, year)	IFSP date (month, day, year)
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SECTION 6: TRANSITION CHECKLIST / OUTCOME

Duplicate as needed.	Outcome number
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The IFSP must include the steps to be taken to support the transition of the child into, within and from the First Steps early intervention system. This section may be completed during a routine review or evaluation of the IFSP, or at other times as appropriate. This includes activities designed to ensure a smooth transition from the hospital to home, the selection of service providers, transition between center-based services to home, the addition or reduction of services, or the transition to services at age 3 OR when the child is no longer eligible. Transition activities include discussions with, and training of, parents regarding future placements, procedures to prepare the child, family and service providers for these changes. With parental consent, information about the child is shared with receiving providers to ensure continuity of services and assist in planning. Transition needs should be expanded in a specific Outcome within the IFSP and will provide more specificity/detail.

PROJECTED DATE(S):	<p>Transition activities into the First Steps program:</p> <ul style="list-style-type: none"> ● Transition from hospital, neonatal intensive care unit to home, and into early intervention services to ensure that no disruption occurs in necessary services. <p>Transition activities within the First Steps program:</p> <ul style="list-style-type: none"> ● Family changes that may affect IFSP service delivery (i.e., employment, birth or adoption of sibling, medical needs of other family members) ● Child changes that may affect IFSP service delivery (i.e., hospitalization or surgery, placement in a child care program, addition of new equipment or technology, medication changes) ● Introduction of new or a change in Service Provider(s) ● Termination of existing IFSP services ● Other: _____ 	PROJECTED DATE(S):	<p>Transition activities out of the First Steps program:</p> <p>Exiting the First Steps system:</p> <ul style="list-style-type: none"> ● Contact CSHCS Customer Service/Prior Authorization Unit (if applicable) to explore future service options. ● Explore community program options for our child ● Explore community program options for our family ● Discuss transition process and our rights and responsibilities under Part C ● Send specific information to the local education agency, with our informed, written consent, at our child's age 18 months ● Send specific information to the local education agency, with our informed, written consent, at our child's age 30 months ● Send specific information to community programs, upon our informed, written consent, to facilitate service delivery or transition from the First Steps early intervention system ● Convene the transition meeting ● Other: _____
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Outcome: (related to transition)

STRATEGIES FOR WORKING TOWARD TRANSITION	WHO IS RESPONSIBLE?	TIMELINE / EXPECTED DATE OF COMPLETION

Name of child	Date of birth (month, day, year)	IFSP date (month, day, year)
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SECTION 8: EARLY INTERVENTION SERVICES

This page is part of the electronic record. Early intervention services must meet the developmental needs of the child and family and are based upon the Outcomes developed. Services are selected in collaboration with the parents and provided under public supervision by qualified personnel in conformity with the IFSP. Unless otherwise indicated, the early intervention services listed below are funded through the Central Reimbursement Office. Any service that is to be provided in a setting other than the natural environment of the child must be documented in Section 7 of the IFSP.

EARLY INTERVENTION SERVICES OPTIONS			LOCATION
Assistive technology	Nursing services	Social work services	1. Program designed for children w/ delays/disabilities 2. Program designed for typically developing children 3. Home 4. Hospital (<i>inpatient</i>) 5. Residential facility 6. Service provider location 7. Other setting
Audiological services	Nutrition services	Special instruction	
Health services	Occupational therapy	Speech/language therapy	
Medical diagnostic services	Physical therapy	Transportation	
	Psychological services	Vision services	

SERVICES	RELATED OUTCOME	FREQUENCY AND INTENSITY OF SERVICE	START DATE	END DATE	LOCATION CODE	✓ IF ON-SITE	PROVIDERS INFORMATION NAME AND AGENCY
Service Coordination	ALL	Up to 4 contacts per month					

The contents of this completed IFSP have been fully explained to me. I give informed, written consent to implement the services described in this section of the IFSP. I further acknowledge that I am responsible to meet all First Steps financial obligations. I am aware that if I would like further consideration of my income or financial deductions, that I may provide documentation of income or family medical expenditures to the Service Coordinator. The Service Coordinator is responsible to review the income and deductions within 30 days of my request. If income verification was not provided, I acknowledge that I will be billed the maximum allowable monthly co-payment fee. I have received a written copy of parent rights, opportunities and responsibilities within the First Steps early intervention system, and the Intake / Service Coordinator has explained this information verbally as well.

Signature of parent / guardian / surrogate parent	Date (month, day, year)	Signature of parent / guardian / surrogate parent	Date (month, day, year)
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SECTION 9: OTHER SERVICES

To the extent appropriate, the IFSP must include services that are **not required or covered** under Part C. Please check the other resources utilized by the family.

- | | | |
|--|---|--|
| <input type="checkbox"/> No other services | <input type="checkbox"/> Family Preservation | <input type="checkbox"/> Indiana School for the Blind |
| <input type="checkbox"/> Head Start / Early Head Start | <input type="checkbox"/> Waiver | <input type="checkbox"/> Other |
| <input type="checkbox"/> Healthy Families | <input type="checkbox"/> Respite | <input type="checkbox"/> Outreach for Deaf / Hard of Hearing |
| <input type="checkbox"/> TANF | <input type="checkbox"/> Cochlear implant | <input type="checkbox"/> Preschool |
| <input type="checkbox"/> WIC | <input type="checkbox"/> Psychosocial | <input type="checkbox"/> Hoosier Healthwise |
| <input type="checkbox"/> Child care | <input type="checkbox"/> Medical Intervention | <input type="checkbox"/> CSHCS |

BASED ON THE ATTACHED SUMMARY OF THE CHILD'S PRESENT LEVEL OF PERFORMANCE AND EVALUATION INFORMATION, I AGREE THAT THE RECOMMENDED THERAPIES ARE NECESSARY AND APPROPRIATE.

Printed name of physician	Telephone number ()	Fax number ()
Signature of physician	Date (month, day, year)	

Please return the signed copy of this page to the child's Intake/Service Coordinator, _____

Telephone number ()	Fax number ()
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If you have additional questions relating to the evaluation information for this child, you may contact the Eligibility Team (ED):

Name of contact	Telephone number ()	Fax number ()
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