



Individualized Family Service Plan



Initial or Annual IFSP Meeting:
Next Review Date:

/Meeting Date:
Timeline for 90-day Transition Meeting:

45 Day Timeline for Initial IFSP:

SECTION 1: DEMOGRAPHIC INFORMATION

Child's Name: _____ Date of Birth: _____ Chronological Age: _____ Adjusted Age: _____ Gender: M or F

Race/Ethnicity: American Indian or Alaska Native Asian or Pacific Islander Black or African American (not Hispanic) Hispanic or Latino White (not Hispanic) Multi Other

Eligibility: **Category 1** Condition(s) and ICD-9 codes: _____

Category 2 Significant Delay - Additional Conditions and ICD-9 Codes: _____

Primary Care Physician: _____ Phone/Fax: _____

Referred to BCW per CAPTA requirements? Yes No

Interpretation services provided? Yes No

Benefit Information:

Children's Medical Services (CMS) Yes No Pending

CMOs Yes No Pending

PeachCare for Kids Yes No Pending

SSI Yes No Pending

Traditional Medicaid Yes No Pending

Private Insurance Yes No Pending

Family declined access

CMO Number:

Medicaid Managed Care (CMO) Provider: Amerigroup PeachState WellCare

Medicaid Number:

PeachCare Number:

Insurance Company:

Insurance Number:

Family Cost Participation: %

<p>Parent(s):</p> <p>Address _____</p> <p>City _____ GA , Zip _____</p> <p>County of Residence _____</p> <p>Phone - Day (w/h) _____ Eve (w/h) _____</p> <p>Best time to call _____ Fax _____</p> <p>Email Address _____</p> <p>Parent(s) Primary Language/Mode of Communication _____</p> <p>Child's Primary Language/Mode of Communication _____</p>	<p>Parent or Other Name(s):</p> <p>Address _____</p> <p>City _____ GA , Zip _____</p> <p>County of Residence _____</p> <p>Phone - Day (w/h) _____ Eve (w/h) _____</p> <p>Best time to call _____ Fax _____</p> <p>E-mail Address _____</p> <p>Primary Language/Mode of Communication _____</p> <p>Is child placed in Foster Care? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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SECTION 2: SERVICE COORDINATOR'S INFORMATION

Intake Service Coordinator's Name _____ Phone _____ Fax _____

Ongoing Service Coordinator's Name _____ Phone _____ Fax _____

Agency _____ Address _____

Other ways to contact (e-mail, cell-phone, pager, etc.) _____

SECTION 3: IDENTIFICATION OF NATURAL ENVIRONMENT(S)

Tell me about the activities and routines in which your child and family are involved? Where does your child spend time (at home, community, neighborhood, childcare, etc.)? With whom does your child spend time (immediate family members, relatives, neighbors, friends, child care providers, etc.)? How often/how much time (include day/evening/weekend and frequency)? Does your child attend child care or preschool? How many days per week and how many hours per day? What are some of the special activities or events that your family enjoys or celebrates?

Tell me about your child's most enjoyable toys, games, activities, routines, events, places. What songs, stories, pets, animals, foods, and places does your child enjoy?

Tell me about the most difficult time of the day for you and your child. Tell me about routines or activities that you find difficult or frustrating (for you or your child).

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Tell me about activities/routines that your family are not currently involved in because of your child's special needs, but that you are interested in doing now or in the near future.

SECTION 4: ALL ABOUT OUR CHILD AND FAMILY

Tell me about the strengths/resources your family has for meeting your child's needs.
(What family strengths are helpful in supporting your child? Who do you know in your community? Where do you go when you need help? etc.)

Tell me about your priorities and concerns related to your child's growth and development.

Tell me about your hopes and dreams for your child.

This section was completed by _____

Our family chose not to complete this page. Family initials _____

SECTION 5: IFSP OUTCOMES Outcomes should be based on the child's needs and family capacity needs identified through evaluation and assessment. Outcomes must be written in language that is easily understood by all IFSP team members.

Outcome #:	A. Outcome/Long Term Functional Goal: What would we like to see change as a result of early intervention?		
B. Current Level of Function: What is happening now (evaluation/assessment information)?		C. Progress Statement: How will we know we are making progress toward A? What will be different?	
Service Provider Review: Date Completed _____ Is Progress Statement "C" <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Situation changed, no longer applies?			
<small>Note: This section should only be completed by a service provider who cannot attend the IFSP review meeting. Complete and give to the service coordinator prior to the IFSP meeting. Include input regarding successful functional activities used in supporting the family and child toward outcome attainment, current status, etc. See directions for this section.</small>			
Strategies that will be used to support the child's participation in the family's routines/activities (please #):			People/resources/supports/support tools:

SECTION 6: NATURAL ENVIRONMENTS (NE) Early Intervention supports and services must be provided in Natural Environments (settings that are natural/typical for the child's age peers who have no disabilities) to the maximum extent appropriate, and can only be provided in settings other than Natural Environments when outcomes cannot be achieved satisfactorily in Natural Environments. IDEA (the law) requires justification to support the Individualized Family Service Plan team decision that outcome/strategies cannot be achieved satisfactorily in NE.

Why outcomes/goals cannot be achieved in NE?	How will interventions be included in Natural Environments?	Plan/timeline to move service into Natural Environments.
<input type="checkbox"/> N/A		

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Why outcomes/goals cannot be achieved in NE?	How will interventions be included in Natural Environments?	Plan/timeline to move service into Natural Environments.
<input type="checkbox"/> N/A		

SECTION 7: EARLY INTERVENTION SERVICES Early intervention services are selected by the IFSP team. The team includes the parent(s). Services must meet the developmental needs of the child identified through 1) evaluation, 2) assessment, and 3) the priorities of the family related to enhancing the child's development based upon the outcomes developed.

Early Intervention (EI) Service Code		Location Code	Fund Code
AT Assistive Technology AS Audiological Services FTC Family Training, Counseling, Home Visits HS Health Services MS Medical Services NU Nutrition Services NS Nursing Services OT Occupational Therapy SLP Speech/Language Pathology	PS Psychological Services PT Physical Therapy SC Service Coordination SW Social Work Services SI Special Instruction TR Transportation VS Vision Services * Other Required Services * Requires state office approval	1. Program designed for children with developmental delays or disabilities (special purpose facility) 2. Program designed for typically developing children (e.g., child care, Early Head Start, etc.) 3. Home (includes community settings such as parks, stores, restaurants, recreational facilities, etc.) 4. Hospital (in-patient) 5. Residential facility 6. Service provider location (clinic) 7. Other setting (non-natural environments)	A. Traditional Medicaid B. PeachCare for Kids C. Children's Medical Services (CMS) D. Private Insurance E. Family Cost Participation _____% F. Early Intervention Service Funds (EISF) _____% G. State Funds H. Other I. CMOs: Wellcare, Amerigroup, PeachState

EI Service Code	BCW Service Provider Name of Individual and Agency	Related to Outcome Number(s)	Frequency/Intensity (times per week/month, minutes per session)	Primary (P) Supplemental Visit (S) Teaming (T) Face-to-Face (F) Other (O)	Expected Start Date M/D/Y	End Date M/D/Y	Location Code	Fund Code(s) Enter all that apply
SC			SC Tier Level:					

Parent Consent for Provision of Early Intervention Services: I have had my parental rights reviewed with me, both verbally and in writing. I understand that all service providers chosen by me to implement this IFSP, including BCW, will share information, both verbally and in writing, only to the extent that it relates to the implementation of the IFSP. I give consent for my child/family to receive the services listed in this IFSP. "Consent" means that I have been fully informed of all information about the activity(s) for which consent is sought in my native language or other mode of communication; that I understand and agree in writing to the carrying out of the activity(s) for which consent is sought; the consent describes that activity(s) and lists any records which will be released and to whom; and the granting of my consent is voluntary and may be revoked in writing at any time. In addition, I may decline a service or services without risking the receipt of any other early intervention service(s) under BCW.

Parent: _____ Date: _____
 Parent: _____ Date: _____

SECTION 8: OTHER SERVICES To the extent appropriate, the IFSP must include services that are not required or covered under Part C. Listing the non-required services does not mean that those services must be provided; however, identifying these services can help the family and service providers to have a comprehensive "picture" of the child's needs. "Other services" should address health needs and service gaps identified for the child. "Other services" must correspond to family identified outcomes/strategies listed in Section 5.

Other Services	Provider	Funding Source	Comments

SECTION 9: IFSP DEVELOPMENT TEAM AND CONTRIBUTORS At a minimum, the IFSP/PSP meetings must include the parent(s), the service coordinator, and person(s) directly involved in conducting evaluations and assessments. Other participants may include other family members or an advocate or person outside the family as requested by the parent, and as appropriate, persons who will be providing supports/services to the child or family. The child's primary care physician (PCP), with parent/guardian consent, is also a member of the IFSP team. Participants unable to attend the IFSP meeting may participate by other means.

Participation Codes: **A = Attended** **S = Speaker phone** **T = Telehealth**
R = Report/recommendations **V = Verbal information** **O = Other, please specify**

Printed Name	Position/Role	Agency (if applicable)	Telephone # and Fax (if applicable)	Signature/Credentials (If attending)	Participation Code
	Parent				
	Parent				
	Service Coordinator				
	Primary Care Physician (PCP)				

Reason for Initial IFSP Delay (beyond 45 days):

- N/A – Initial IFSP completed within 45 days OR Annual IFSP
 Child illness/hospitalization Family response time Family requested delay BCW response time Other (specify): _____
 Delay in obtaining Parent/Guardian consent (**CAPTA/DFCS referrals only**)

Department of Family & Children Services (DFCS) or Child Protective Services (CPS) Case Worker: Invited Attended Not Applicable (Child & Family not involved with DFCS/CPS)

IFSP reviewed by Early Intervention Coordinator/Designee _____ Date: _____

SECTION 10A: TRANSITION The IFSP must include the steps to be taken to support the transition of the child from Babies Can't Wait.

Transition Steps (Check all that apply)	Specific Actions (List the Step # and Give a Brief Summary of Actions)	Who is Responsible?	Projected Start Date	Date to be Completed
<p>1. Every IFSP:</p> <p><input type="checkbox"/> Ongoing discussion with, and training of, parents regarding future placements and other matters related to the child's transition. Should, when appropriate, include discussions of family priorities, program options and eligibility requirements, program visitation, and how to prepare the child for changes in service delivery.</p> <p>2. IFSP prior to Child's 2nd Birthday</p> <p><input type="checkbox"/> Complete the Notice of Intent to Transmit Notification Information.</p> <p><input type="checkbox"/> Does not apply at this time.</p> <p>3. IFSP prior to Child turning 30 months of age.</p> <p><input type="checkbox"/> Complete Parent Consent for Preschool Special Education Services referral.</p> <p><input type="checkbox"/> Give <u>Transition at Age 3: Steps for Success</u> booklet at least by 27 months.</p> <p><input type="checkbox"/> Does not apply at this time.</p> <p>4. 9 months to 90 days prior to Child's 3rd Birthday:</p> <p><input type="checkbox"/> Convene transition meeting and complete <u>Section 10B: Transition</u>.</p> <p><input type="checkbox"/> Does not apply at this time.</p> <p>NOTE: If Child will be leaving the program before age three (3). Complete the <u>Section 10B: Transition</u> anytime a child will be exiting the Program. This includes leaving at other than age 3. (e.g., Child moves out of state or family chooses to end involvement with BCW).</p>				

Notice of Intent to Transmit Notification Information to the Local School System: (Complete at IFSP prior to Child's 2nd Birthday)

In order to assist the Department of Education in fulfilling Federal child find responsibilities under the Individuals with Disabilities Education Act, Babies Can't Wait is required to provide individual child and family information to local school systems prior to each child's transition at age three unless the family declines in writing to have this information shared. In the month immediately following my child's 2nd birthday, his/her name, date of birth and my contact information (address, telephone number) will be sent to the Special Education Director in the school system where my child resides. In cases where there are county and city systems, the information will be sent to both systems. In the event that my child entered Babies Can't Wait after 24 months of age, this information will be transmitted in the month immediately following the development of his/her initial Individualized Family Service Plan.

This information has been explained to me and I understand it. _____ Parent(s) Signature _____ Date

Parental Opt Out of Notification Activity:

I am exercising my right to **opt out** of participation in this notification activity and I do not want my individual child and family information sent to the school system as described above. I understand that if I **do not** sign below, notification information related to my child and family, as described above, **will be shared** with the local school system in accordance with timelines outlined in the action proposed. I also understand that opting out **will not** affect any future decisions I may make regarding my child's transition planning as he/she prepares to transition from Babies Can't Wait at three years of age.

_____ Parent Signature _____ Date

Referral: (Complete at the last IFSP prior to 30 months)

I **consent** to have my child referred to the local school system for consideration of eligibility for preschool special education services.

_____ Parent Signature _____ Date Date Referral was Made: _____

**O
R**

I **do not give my consent** to have my child referred to the local school system for consideration of eligibility for preschool special education services. I understand that the eligibility determination/IEP process may extend past my child's third birthday if my consent is not given in a timely manner.

_____ Parent Signature _____ Date

SECTION 10A: TRANSITION (CONTINUED): Individual transition meetings must be convened at least 90 days and no more than 9 months prior to the child's third birthday. If this timeline was not met, please indicate reasons below.

Reason for Delay in Transition Meeting (Meeting held less than 90 days before child's 3rd birthday):

- | | |
|---|---|
| <input type="checkbox"/> N/A (meeting was held timely OR Child is less than 2 years old) | <input type="checkbox"/> Family requested delay |
| <input type="checkbox"/> Child illnesses/hospitalizations | <input type="checkbox"/> Initial referral to BCW received less than 135 days prior to 3 rd birthday
(45 days to IFSP + 90 day transition meeting) |
| <input type="checkbox"/> Delayed scheduling by BCW personnel /Service Coordinator/Contract provider | <input type="checkbox"/> Limited availability of local school system personnel |
| <input type="checkbox"/> Family newly transferred to District from another District | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Family response time | |

CHILD IS YOUNGER THAN 27 MONTHS OF AGE. Defer and leave Section 10B TRANSITION PLAN blank.

Service Coordinator's Initials:

SECTION 10B: TRANSITION PLAN

Outline/Identify transition activities up to this point.

List the priorities for the child and family during the transition process.

Summary of discussion with family:	Summary of discussion with family:
------------------------------------	------------------------------------

Attendees: Parental consent must be obtained prior to inviting Part B and any other community programs to the Transition Planning meeting.

Other community programs may include but are not limited to:

- Child Care Inclusion Coordinators
- Head Start
- Preschool
- Private services
- Current service providers
- Home visiting programs
- Georgia PINES
- Georgia Sensory Assistance Project, etc.

Document attendees at the transition meeting on the last page of the Transition Plan.

Community Resources and Programs: List all non-part B agencies or programs (as identified by the parent/family) that were in attendance at the transition meeting and list any resources that were discussed or considered during the transition meeting.

- | | | |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Was a representative from the child's local school system invited to the transition meeting? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Did a representative from the child's local school system attend the transition meeting? |

Transition Meeting Timeline: The transition meeting **MUST** occur at least 90 days and no more than 9 months prior to the child's third birthday.

Date of Child's 3rd Birthday:

Date Transition Meeting Occurred:

SECTION 10B: TRANSITION PLAN (CONTINUED)

TRANSITION STEPS: SPECIFIC ACTION(S)	WHO IS RESPONSIBLE?	PROJECTED START DATE	DATE TO BE COMPLETED
<p>Information To Be Shared : Send specified information to Part B and/or other community programs, with parental consent, at child's age of 30 months, unless parent/family has signed NOT TO HAVE INFORMATION RELEASED TO LSS.</p> <p>What information is to be sent/shared? Discuss with family what information they want to share.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Current IFSP <input type="checkbox"/> Current evaluations and assessments <input type="checkbox"/> Determination of eligibility documentation <input type="checkbox"/> Progress notes <input type="checkbox"/> Other (specify) _____ 			

LOCAL SCHOOL SYSTEM (LSS) CONTACT INFORMATION

System Name: _____

Special Ed Preschool Contact Name: _____

Address: _____

City: _____ GA, Zip: _____

Phone: _____ Fax: _____

Email Address _____

SECTION 10B: TRANSITION PLAN (CONTINUED)

Identify other programs and services the family is interested in learning more about. Please note how you will assist the family with acquiring this information.

Program/Service	Specific Action(s)	Who Is Responsible?	Projected Start Date	Date To Be Completed
<input type="checkbox"/> Children's Medical Services				
<input type="checkbox"/> Children 1 st				
<input type="checkbox"/> Private Preschool/Child Care				
<input type="checkbox"/> Head Start				
<input type="checkbox"/> Private Therapy				
<input type="checkbox"/> Georgia PINES				
<input type="checkbox"/> Georgia Sensory Assistance Project				
<input type="checkbox"/> Part B/Preschool Special Ed./LSS				
<input type="checkbox"/> Parent to Parent of Georgia				
<input type="checkbox"/> Other:				
<input type="checkbox"/> Other:				

TRANSITION MEETING SIGNATURES AND PARTICIPATION CODES

Participation Codes:

A = Attended

S = Speaker phone

T = Telehealth

R = Report/recommendations

V = Verbal information

O = Other, please specify

CODE	ROLE	SIGNATURE	DATE
A	Parent		
	Parent		
A	Service Coordinator		

Reviewed by Early Intervention Coordinator/Designee: _____ Date: _____

SECTION 11: IFSP REVIEW: IFSP REVIEW 6 MONTH OR OTHER

Child's Date of Birth: _____

Revision Date: _____

This page documents all IFSP revisions and reviews. Progress statements must be evaluated, minimally, at 6 month reviews, annual reviews, and up to 30 days prior to the child turning 3.

Evaluation Codes: 0 = Progress statement not met 1 = Progress statement partially met 2 = Progress statement met 3 = Situation changed, no longer applies

Outcome #	Progress Summary	Revisions to Progress Statement or Strategies	Eval Code
		<input type="checkbox"/> New Progress Statement	
		<input type="checkbox"/> New Progress Statement	

PARTICIPANTS

Codes: A = Attended S = Speaker phone T = Telehealth R = Report/recommendations V = Verbal information O = Other, please specify

Role	Code	Signature and Date	Role	Code	Signature and Date
Parent	A				
Service Coordinator	A				

MODIFICATIONS

Legend: 1 = Current Service/Support to Modify + = Addition of Service/Support - = Termination of Service/Support

*See back for Location and Fund Code Descriptors

Legend	Service/Support Modified	BCW Service Provider	Related to Outcome #'s	Frequency / Intensity	P/S/T/F/O	Expected Start Date M/D/Y	End Date M/D/Y	Location Code	Fund Code(s)

Interpretation Services Provided: Yes No

Parent Consent for Provision of Early Intervention Services: I have had my parental rights reviewed with me, both verbally and in writing. I understand that all service providers chosen by me to implement this IFSP, including BCW, will share information, both verbally and in writing, only to the extent that it relates to the implementation of the IFSP. I give consent for my child/family to receive the services listed in this IFSP. "Consent" means that I have been fully informed of all information about the activity(s) for which consent is sought in my native language or other mode of communication; that I understand and agree in writing to the carrying out of the activity(s) for which consent is sought; the consent describes that activity(s) and lists any records which will be released and to whom; and the granting of my consent is voluntary and may be revoked in writing at any time. In addition, I may decline a service or services without risking the receipt of any other early intervention service(s) under BCW.

Parent(s): _____ Date: _____

Reviewed by Early Intervention Coordinator/Designee: _____ Date: _____

PLEASE NOTE:

**THE FOLLOWING PAGES ARE THE
CHILD IFSP SUMMARY FORM**

THESE PAGES ARE NOT

PART OF THE INDIVIDUALIZED FAMILY SERVICE PLAN

To the Attention of:

Date Mailed/Faxed:

This document is a summary of the Individual Family Service Plan (IFSP) developed for this child by his or her Babies Can't Wait team. It is provided to you with parental consent. The complete IFSP document is available upon request.

Child's Name:		D.O.B.:
Primary Care Physician:		Physician Phone #:
Check Appropriate Box:	<input type="checkbox"/> Initial Eligibility Evaluation <input type="checkbox"/> 6 Month Review <input type="checkbox"/> Annual Assessment <input type="checkbox"/> Interim Review	IFSP Meeting Date:
Eligibility Status:	<input type="checkbox"/> Eligible: (IFSP active) <input type="checkbox"/> Not Eligible: (IFSP not active)	Date of Evaluation:
Evaluation Tools Used:	Scores:	

IFSP OUTCOMES

Outcome #:	A: Outcome/Long Term Functional Goal:	
B: Current Level of Function:	C: Progress Statement – How will we know we're making progress?	
D: Progress Made: (complete only at 6 month, modifications or annuals)		

*Attach any additional outcomes on separate page.

Child Individualized Family Service Plan (IFSP) Summary Form

IFSP OUTCOMES (Continue)

Outcome #:	A: Outcome/Long Term Functional Goal:	
B: Current Level of Function:	C: Progress Statement – How will we know we’re making progress?	
D: Progress Made: (complete only at 6 month, modifications or annuals)		
Outcome #:	A: Outcome/Long Term Functional Goal:	
B: Current Level of Function:	C: Progress Statement – How will we know we’re making progress?	
D: Progress Made: (complete only at 6 month, modifications or annuals)		

*Attach any additional outcomes on separate page.

PROVIDERS

Primary Service Provider (Name and Title): _____

Phone #: _____

EI Service Code	BCW Service Provider Name of Individual and Agency	Frequency/Intensity (times per week/month, minutes per session)	Primary (P) Supplemental Visit (S) Teaming (T) Face-to-Face (F) Other (O)	Anticipated Start Date MM/DD/YY	End Date MM/DD/YY
SC		SC Tier Level:			

NOTE: Primary Service Provider (PSP) is the model of teaming used by Babies Can't Wait. It is an evidence-based early childhood practice. PSP uses a team of professionals that meet regularly to provide on-going supports, services, and consultation related to areas identified as priorities on the IFSP.

BABIES CAN'T WAIT PROGRAM CONTACT

District Name:	
District Address:	
District Phone #:	
District Fax #:	

Completed By:

Signature:	
Printed Name:	
Contact Number:	

Notes: