



Individualized Family Support Plan and Evaluation Report

Form A: Your Family's Information

Page \_\_\_ of Form A

Child's Name: Last First MI A.K.A:

DOB: Child's ID#: Gender: Male Female

Child's Primary Language/Mode of Communication: English Spanish Creole Other:

Check One: Parent Guardian Foster Parent Surrogate Parent Other:

Name(s):

Address:

City: Zip Code: County:

Phone: Work Phone: Cell Phone:

Best time to call: E-mail:

Primary language used in home/mode of communication: English Spanish Creole Other:

Check One: Parent Guardian Foster Parent Surrogate Parent Other:

Name(s):

Address:

City: Zip Code: County:

Phone: Work Phone: Cell Phone:

Best time to call: E-mail:

Primary language used in home/mode of communication: English Spanish Creole Other:

Is an interpreter needed for the family? Yes No If so, what kind of interpreter?

The following people can help you with your questions and concerns:

Service Coordinator: Agency:

Phone: Fax: E-mail:

Address: City: Zip Code:

Family Resource Specialist:

Phone: Fax: E-mail:

Address: City: Zip Code:

Referral Date: IFSP Periodic Review Due Date:

Interim IFSP Date: IFSP Periodic Actual Review Date:

Initial IFSP Date: Annual IFSP Due Date:

Current IFSP Date: Transition Conference Due Date:

Name: \_\_\_\_\_  
ID#: \_\_\_\_\_

DOB: \_\_\_\_\_  
Service Coordinator: \_\_\_\_\_

IFSP Date: \_\_\_\_\_

**Form B: Planning for Your Child's Evaluation/Assessment**

Page \_\_\_\_ of Form B

Date(s) this Information Gathered:

Chronological Age:

**Tell us about your child's health:**

Was your child born full term?  Yes  No  
How many weeks? \_\_\_\_\_ Birth weight: \_\_\_\_\_  
Date of your child's last well-child check-up: \_\_\_\_\_  
Are immunizations current?  Yes  No  
Is your child currently on any medication(s)?  Yes  No  
If so, what types and why:

Does your child have allergies?  Yes  No Describe:

Does your child have a medical diagnosis?  Yes  No  
If so, what is it?

Does your child see any medical specialists?  
 Yes  No If so, who and what type:

Has your child been hospitalized?  Yes  No  
Please tell us when and why:

**Tell us about your child's vision and hearing:**

Has your child's hearing been previously screened or tested?  
 Yes  No When? \_\_\_\_\_  
Do you have concerns about your child's hearing?  
 Yes  No Describe:

Has your child's vision been previously screened or tested?  
 Yes  No When? \_\_\_\_\_  
Do you have concerns about your child's vision?  
 Yes  No Describe:

**Tell us about your child's sleep patterns/nutrition:**

Describe your child's sleep patterns (bedtime, naps, hours of sleep):

Describe your child's nutritional habits/preferences:

**Your Insurance Information:**

**Medicaid (Title XIX)**

Medicaid HMO/PSN  Yes  No  Pending

Group: \_\_\_\_\_

CMS  Yes  No  Pending

CMS Nurse Case Manager: \_\_\_\_\_

Medicaid Medipass  Yes  No  Pending

SSI  Yes  No  Pending

Medicaid #: \_\_\_\_\_

Comments/Changes: \_\_\_\_\_

KidCare/MediKids  Yes  No  Pending

CMS (Title XXI)  Yes  No  Pending

Private Insurance:  Yes  No

Type:  HMO  PPO

Company Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Policy/Individual #: \_\_\_\_\_ Group #: \_\_\_\_\_

Primary Health Care Provider: \_\_\_\_\_

**Your Child's Developmental Screening:**

A developmental screening was conducted  Yes  No If yes, please check which tools/methods used:

Developmental Checklists (specify)  Parent Report  Observation  Record Review  Ages & Stages

Other: \_\_\_\_\_ Language used: \_\_\_\_\_

Does the collected information from above indicate a possible developmental delay/concern in any of the following areas:

Fine motor  Gross motor  Communication  Cognitive  Social-emotional  Adaptive-self-help skills

Comments: \_\_\_\_\_

**Describe any other information about the child's health, development, and/or family medical history that may be important for the team to know:**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ IFSP Date: \_\_\_\_\_  
ID#: \_\_\_\_\_ Service Coordinator: \_\_\_\_\_

**Form C: Your Family's Routines/Concerns/Priorities/Resources**

Page \_\_\_\_ of Form C

Date(s) this Information Gathered: \_\_\_\_\_

**Family:** Who are the people living in your home? Please include names and relationships. Include ages and gender of children.

**Daily Routines:** What are your child's and your family's daily activities? Where does your child spend the day? With whom does your child regularly interact? (Include your child's activities, routines and favorite toys.) What activities, routines, and places are challenging to your child and family?

**Family's Areas of Concern:** What concerns do you have about your child's development and/or any other family challenges? Questions and concerns about your child may include issues such as feeding/nutrition (*such as weight gain or loss, difficulties with eating, special diets or feeding equipment, elimination habits*), sleeping, playing, communicating, behavior, health, transportation, food/shelter, etc.

**Priorities:** Which concerns above would you like to focus on first? What do you hope Early Steps can help you with?

**Friends/Supports/Resources:** When you need help, who do you call and how do they help you? What types of resources do you have to meet your family's needs? These may include family strengths, childcare, transportation and financial resources.

Recommendations for Evaluation and Assessment/Team Updates: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ IFSP Date: \_\_\_\_\_  
 ID#: \_\_\_\_\_ Service Coordinator: \_\_\_\_\_

**Form D: Your Child's Eligibility Evaluation Information**  
 (Complete Form D for the initial IFSP only)

Page \_\_\_\_ of Form D

*For your child's first IFSP, an evaluation may be completed with your child to determine eligibility, prior to or during assessment. The eligibility information is recorded on this page.*

Date of Evaluation (if performed): \_\_\_\_\_ Chronological Age: \_\_\_\_\_ Language Used: \_\_\_\_\_

Method(s) of Evaluation:  Test Instrument(s) Administered: \_\_\_\_\_

Parent Report  Professional Observation  Collateral Information/Source: \_\_\_\_\_

<b>Eligibility Evaluation Results</b>	<b>Results</b>
<b>Using Hands and Body</b> (Gross/Fine Motor Skills) Comments: _____	
<b>Eating, Dressing, and Toileting</b> (Self-Help/Adaptive Skills) Comments: _____	
<b>Expressing and Responding to Feelings and Interacting with Others</b> (Social/Emotional) Comments: _____	
<b>Playing, Thinking, Exploring</b> (Academic/Cognitive including pre-literacy skills) Comments: _____	
<b>Understanding and Communicating</b> (Receptive and Expressive Communication) Comments: _____	

**Evaluation Team Signatures**

The eligibility evaluation team is the same as the assessment team. Please see Form E for signatures.

The eligibility evaluation team is different from the assessment team. Please sign below.

Evaluator: \_\_\_\_\_ Discipline: \_\_\_\_\_ Signature: \_\_\_\_\_

Evaluator: \_\_\_\_\_ Discipline: \_\_\_\_\_ Signature: \_\_\_\_\_

Evaluator: \_\_\_\_\_ Discipline: \_\_\_\_\_ Signature: \_\_\_\_\_

**Eligibility Determination**

Eligible for Early Steps (Part C: Early Intervention) based on the following:

Established Condition of: \_\_\_\_\_

Developmental Delay in the area(s) of: \_\_\_\_\_

Not eligible for Early Steps (Part C: Early Intervention) based on evaluations completed this day and the IFSP does not need to be completed. The evaluation team makes the following recommendations to the family: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ IFSP Date: \_\_\_\_\_  
 ID#: \_\_\_\_\_ Service Coordinator: \_\_\_\_\_

**Form E: Your Child's Assessment Information**

Page \_\_\_\_ of Form E

*A developmental assessment is completed with your child and/or ongoing assessment information is gathered. This information helps us understand your child's developmental strengths, as well as some of the things that are challenging for your child and may be affecting how he/she is able to participate in family and community activities.*

Date of Assessment: \_\_\_\_\_ Chronological Age: \_\_\_\_\_ Language Used: \_\_\_\_\_  
 Method(s) of Assessment:  Test Instrument(s) Administered: \_\_\_\_\_  
 Parent Report/Interview Tool: \_\_\_\_\_  Professional Observation  Collateral Information/Source: \_\_\_\_\_

**Summary of Present Status: Abilities, Strengths, and Needs**

<b>Using Hands and Body</b> (Gross/Fine Motor Skills)	
Things we like and things we do well:	Things that we need help with:
<b>Eating, Dressing, and Toileting</b> (Self-Help/Adaptive Skills)	
Things we like and things we do well:	Things that we need help with:
<b>Expressing and Responding to Feelings and Interacting with Others</b> (Social/Emotional)	
Things we like and things we do well:	Things that we need help with:
<b>Playing, Thinking, Exploring</b> (Academic/Cognitive including pre-literacy skills)	
Things we like and things we do well:	Things that we need help with:
<b>Understanding and Communicating</b> (Receptive and Expressive Communication)	
Things we like and things we do well:	Things that we need help with:

Vision and Hearing Status: \_\_\_\_\_  
 \_\_\_\_\_

Observations/Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Assessor: \_\_\_\_\_ Discipline: \_\_\_\_\_ Signature: \_\_\_\_\_  
 Assessor: \_\_\_\_\_ Discipline: \_\_\_\_\_ Signature: \_\_\_\_\_  
 Assessor: \_\_\_\_\_ Discipline: \_\_\_\_\_ Signature: \_\_\_\_\_

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

IFSP Date: \_\_\_\_\_

ID#: \_\_\_\_\_

Service Coordinator: \_\_\_\_\_

**Form F: Your Family's Outcomes**

**Page \_\_\_\_ of Form F**

**OUTCOME #:** \_\_\_\_ What would you like to see happen for your child and family as a result of Early Steps supports and services?

**GOALS, TIMELINES AND CRITERIA FOR PROGRESS:** When will we review progress toward this outcome and what will progress look like?

**STRATEGIES:** Who will do what within your child's everyday routines, activities, and places to achieve this outcome?

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ IFSP Date: \_\_\_\_\_  
 ID#: \_\_\_\_\_ Service Coordinator: \_\_\_\_\_

**Form G: Your Family's Supports and Services**

Page \_\_\_\_ of Form G

Services authorized by the IFSP team to address identified family/child outcomes.

Date	Service	Outcome #	Units	Frequency, Intensity, Group (G) or Individual (I)	Provider Information (Name/Discipline/Agency) <i>*Indicates the Primary Service Provider (PSP)</i>	Location Code	Natural Environment Y / N	Start Date Authorization Period	End Date	Payer of Service

**Location Codes:** 1=Home 3=Hospital 4=School 5=Childcare Center 6=Other 7=Clinic 8=Residential Facility 9=Early Intervention Classroom A=Community Agency F=Family Daycare Home P=Public Place **Service Codes** (optional): See IFSP Guidance Document

**NATURAL ENVIRONMENT JUSTIFICATION:** Supports and services must be provided to your child in settings that are natural or typical for children of the same age (natural environments). If, as a team, we decide that we cannot provide a service in a natural environment, we need to explain how we made that decision:

**COMPLETE ONLY FOR EARLY INTERVENTION SESSIONS:**  
 Addresses the following domain(s):  Fine motor  Gross motor  Communication  Cognitive  Social-emotional  Adaptive-self-help skills  
 Early Intervention Sessions are:  Individual (Medicaid procedure code T1027SC or T1027HM)  
 Group (Medicaid procedure code T1027TTSC or T1027TTHM)  
 ICD9 Code(s): \_\_\_\_\_ ICD9 Description(s): \_\_\_\_\_

**MODIFICATIONS TO SERVICES**  
 I understand that Form G serves as prior notice of proposed new, changed, or terminated services as written above and I understand the reason(s) for taking the action(s).  
 I have received a copy and explanation of my procedural safeguards (*Summary of Family Rights*).  
 Parent/Guardian Signature: \_\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 =====  
**Consent for Services for Children in Custody of Department of Children and Families (DCF) Under Chapter 39 F.S.**  
 I give consent for medical care and treatment per 743.0645 F.S. and as modified in this IFSP.  
 \_\_\_\_\_  
 DCF Caseworker / Designee Signature Title Date

**OTHER SERVICES:** In addition to the Early Steps services listed above, you have identified that your child and family receive, or may like help arranging to receive, the following services such as specialized medical services or those activities or services that you choose independent of those authorized by the IFSP team.

Service/Activity	Activities/Steps Needed	Timeline	Provider/Agency Name

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ IFSP Date: \_\_\_\_\_  
 ID#: \_\_\_\_\_ Service Coordinator: \_\_\_\_\_

**Form H: Your Individualized Family Support Plan Team**

My family and the following individuals participated in the development of this IFSP and/or will help to implement it.

Printed Name / Credential <i>*Indicates a LHCP providing direction and support to ITDS, if applicable</i>	Signature	Position/ Role	Address	Telephone	Receive Copy of IFSP (Family Initial)
		Parent			
		Service Coordinator			
		Primary Service Provider			
		Primary Health Care Provider			

**I/We received the following:**

- Copy of procedural safeguards (*Summary of Family Rights*) for Part C or Part B of IDEA, as appropriate, and these rights and safeguards have been explained to me
- Copy of Early Steps brochure with Central Directory phone number (initial IFSP only)
- Explanation of procedure for requesting new service coordinator
- Copy of Individualized Family Support Plan or understand it will be mailed to me within 15 days

**Informed Consent by Parents/Guardians:**

- I participated fully in the development of this plan.
- I give consent for all of the services described in this Individualized Family Support Plan (IFSP) to be provided as written.
- I do not provide consent for the following service(s) as described in this IFSP to be provided, however, I do give consent for all other services described in this IFSP to be provided: \_\_\_\_\_
- I give permission for copies of this plan to be released to the individuals(s) noted above as indicated by my initials beside each name.

\_\_\_\_\_  
 Parent/Guardian Signature                      Relationship                      Date

\_\_\_\_\_  
 Parent/Guardian Signature                      Relationship                      Date

**Consent for Services for Children in Custody of Department of Children and Families (DCF) under Chapter 39 F.S:**

- I give consent for medical care and treatment per 743.0645 F.S. and described in this IFSP

\_\_\_\_\_  
 DCF Caseworker / Designee Signature                      Title                      Date

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ IFSP Date: \_\_\_\_\_  
ID#: \_\_\_\_\_ Service Coordinator: \_\_\_\_\_

**Form I: Your Family's Transition Plan**

Page \_\_\_\_ of Form I

**Transition Planning Steps (Check all boxes that apply)**

**1. Notification:**

- a.  The *Understanding Notification* brochure was provided. Date Provided: \_\_\_\_\_
- b.  The family opted out of notification. Date: \_\_\_\_\_
- c.  Notification to the school district was provided. Date Provided: \_\_\_\_\_

**2. Program Options:**

- a.  Program options available within the community (e.g., local school district, Head Start, Agency for Persons with Disabilities, other early care and education programs, etc.) were discussed.
- b.  At this time, the family is interested in the following options:

**3. Referral:**

- With family consent, a referral packet was provided to the school district and/or other agencies and community providers as follows:
  - a. Agency/Program to which child is referred: \_\_\_\_\_ Referral Date: \_\_\_\_\_
  - b. Agency/Program to which child is referred: \_\_\_\_\_ Referral Date: \_\_\_\_\_

**4. Transition Conference:**

Date of Conference: \_\_\_\_\_

- a.  Concerns of the family related to transition were discussed. Those concerns are listed below. If there are no concerns, please indicate "none."
  
- b.  List activities to address the above concerns, if applicable.
  
- c.  School district information was provided regarding services to prekindergarten children with disabilities. This information should include the district's evaluation/eligibility process and how the Individual Educational Plan (IEP) is developed.  
Comment:
  
- d.  Services/activities to support our child's transition into a new setting/environment: (Agency/program visitations, parent training, transportation issues, assistive technology needs, immunizations, additional evaluations needed, etc.)

Services/Activities

Person(s) Involved

Timeframe(s)

**We attended the transition conference and participated in the development of this transition plan. We provide consent to the steps and services related to transition.**

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Date

**We attended the transition conference and participated in the development of this transition plan.**

\_\_\_\_\_  
Service Coordinator

\_\_\_\_\_  
IFSP Team Member/Title

\_\_\_\_\_  
Local School District Representative/Title

\_\_\_\_\_  
Community Representative/Agency/Title

\_\_\_\_\_  
IFSP Team Member/Title

\_\_\_\_\_  
Other/Title

Name: \_\_\_\_\_  
 ID#: \_\_\_\_\_

DOB: \_\_\_\_\_  
 Service Coordinator: \_\_\_\_\_

IFSP Date: \_\_\_\_\_

**Form J: Your Family's Individualized Family Support Plan Periodic Review**

Page \_\_\_\_ of Form J

Outcome #	Date Reviewed	Describe Progress / Modification (If these modifications result in a change of service, please complete the <i>Modifications of Services</i> section on Form G)	Status (Check One)
			<input type="checkbox"/> Outcome reached <input type="checkbox"/> New outcome developed (# ____) <input type="checkbox"/> Outcome continued <input type="checkbox"/> Outcome modified
			<input type="checkbox"/> Outcome reached <input type="checkbox"/> New outcome developed (# ____) <input type="checkbox"/> Outcome continued <input type="checkbox"/> Outcome modified
			<input type="checkbox"/> Outcome reached <input type="checkbox"/> New outcome developed (# ____) <input type="checkbox"/> Outcome continued <input type="checkbox"/> Outcome modified
			<input type="checkbox"/> Outcome reached <input type="checkbox"/> New outcome developed (# ____) <input type="checkbox"/> Outcome continued <input type="checkbox"/> Outcome modified
			<input type="checkbox"/> Outcome reached <input type="checkbox"/> New outcome developed (# ____) <input type="checkbox"/> Outcome continued <input type="checkbox"/> Outcome modified
			<input type="checkbox"/> Outcome reached <input type="checkbox"/> New outcome developed (# ____) <input type="checkbox"/> Outcome continued <input type="checkbox"/> Outcome modified

**Team Member Signatures**

Print Name / Credentials <i>*Indicates a LHCP providing direction and support to ITDS, if applicable</i>	Signature	Date