



Participation in IFSP Meeting Documentation

(To be completed by team members participating in IFSP required meeting)

COIFF (Face to Face)

COIFP (Phone)

(circle appropriate code)

Child's Name: _____

DOB: _____

Date of IFSP: _____

Location: _____

Start Time: _____

Team Members Present: _____

(Family)

(Service Coordinator)

Post evaluation and assessment IFSP activities:

- Review and revisit family concerns, priorities, resources, routines and activities.
- Trans-disciplinary approach to the development of integrated outcomes and intervention strategies within the family's everyday routines, activities and places.
- Identification of PSP and appropriate team members to meet the specific family outcomes.
- Documentation of above on IFSP
- Other (specify): _____

End Time: _____

Provider Name: _____

(Print)

Provider Signature: _____

Copy to: Billing with monthly invoice.

PARTICIPATION IN IFSP MEETING DOCUMENTATION INSTRUCTIONS

This form serves two primary purposes:

- Statewide uniform documentation of IFSP Meeting time paid for by contract funds
- Statewide uniform billing documentation for providers participating in IFSP Meetings

Each team member must have a form completed for each IFSP Meeting in which they participate (excluding the initial IFSP as this time is included in the billing for the multidisciplinary evaluation PDEO). During IFSP Meetings, the members participating should appoint a recorder to LEGIBLY complete the form from *Child's Name* to *End Time*. Each participating, billing provider should receive a copy. Each provider circles whether their participation was face to face or by phone at the top, and on the bottom prints their name and signs their copy. The form is submitted with the invoice to the Local Early Steps to document IFSP time billed.

Field Entry Guidance:

Child's Name and DOB: = Child's name whose IFSP is being discussed and their Date of Birth.

Date of IFSP: = The date of the scheduled IFSP meeting.

Location: = The scheduled location of the IFSP meeting.

Start Time: = The time the IFSP meeting begins.

Team Members Present = All the people participating in the IFSP meeting. For the professionals on the team indicate their credentials after their name, i.e. OT, PT, SLP, ITDS, etc.

Post evaluation and assessment IFSP activities: = For each activity that is part of the IFSP meeting discussion check the box. If there is an activity that is not listed check, Other, and describe the activity.

End Time: = The time the IFSP meeting ends.

ALL THE ABOVE FIELDS SHOULD BE IDENTICAL FOR ALL PARTICIPANTS' FORMS

When each participant receives their copy of the completed form, they will complete the remaining fields.

COIFF (Face to Face)

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(circle appropriate code)

Provider Name (Print) LEGIBLE name of provider Provider Signature Provider signature

Each individual provider submits their signed copy to the Local Early Steps with their invoice to document IFSP time billed.