

**FLORIDA DEPARTMENT OF HEALTH, CHILDREN'S MEDICAL SERVICES, EARLY STEPS  
INDIVIDUALIZED FAMILY SUPPORT PLAN (IFSP) and EVALUATION REPORT**

**Form A**

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Child's Name:		A.K.A:	
Last	First	MI	
DOB:	Location of Birth:	Child I.D. #	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female (Check)
Child's Primary Language / Mode of Communication:			
Check one: <input type="checkbox"/> PARENT <input type="checkbox"/> GUARDIAN <input type="checkbox"/> FOSTER PARENT <input type="checkbox"/> SURROGATE PARENT <input type="checkbox"/> OTHER:			
Name(s):			
Address:			
City:	County:	Zip Code:	
Phone:	Alternate Number:	E-mail:	
Best time to call:	Primary Language used in home / Mode of Communication:		
Check one: <input type="checkbox"/> PARENT <input type="checkbox"/> GUARDIAN <input type="checkbox"/> FOSTER PARENT <input type="checkbox"/> SURROGATE PARENT <input type="checkbox"/> OTHER: (Additional Caregiver as Appropriate)			
Name(s):			
Address:			
City:	County:	Zip Code:	
Phone:	Alternate Number:	E-mail:	
Best time to call:	Primary Language used in home / Mode of Communication:		
Is an interpreter needed for the family?	If so, what kind of interpreter?		
<b>Insurance / Resources: (check all that apply)</b>			
KidCare (Title XXI)			
Medicaid:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending	Private Insurance:	<input type="checkbox"/> Yes <input type="checkbox"/> No   Type: <input type="checkbox"/> HMO <input type="checkbox"/> PPO
CMS Network	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending	Company Name:	
MediKids	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending	Primary Care Physician's Name:	
Florida Healthy Kids	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending	Other Resource:	
SSI:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending		
SafetyNet:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending		

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

Service Coordinator Name / Agency:			
Phone:	Fax:		
Address:	City	Zip Code	
Family Resource Specialist:	Phone:		

Current IFSP Date:

Review IFSP Date:

Referral Date:

Review IFSP Date:

Interim IFSP Date:

Review IFSP Date:

Initial IFSP Date:

Review IFSP Date:

6 month IFSP Date Due:

Annual IFSP Date Due:

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**Form B**

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IFSP Date:

Name:

DOB:

**Family Information/Routines/Concerns/Priorities/Resources**

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

Daily Routines: What are your child's and 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, 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. List strengths you feel your family has to meet challenges.

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**Form C**

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IFSP Date:

Name:

DOB:

Chronological Age:

Adjusted Age:

**Pre-Assessment Planning**

**Does the child have an Established Condition?** YES  NO  Condition:

**Collected information indicates possible Developmental Delay/Concern?** YES  NO  In what developmental domains?

Fine motor YES  NO

Communication YES  NO

Gross motor YES  NO

Adaptive-self-help skills YES  NO

Social-emotional YES  NO

Vision YES  NO

Cognitive YES  NO

Hearing YES  NO

**Screening was conducted to identify possible Developmental Delay/Concern?** YES  NO  In what developmental domains?

Fine motor YES  NO

Communication YES  NO

Gross motor YES  NO

Social-emotional YES  NO

Cognitive YES  NO

Adaptive-self-help skills YES  NO

Screening Tool(s):

Screener(s):

Date(s) of Screening:

**Health Status:**

**Medications List:**

**Medical Diagnosis:**

**Nutritional Status:**

**Immunizations Current:** YES  NO

**Hospitalizations:**

**Allergies:**

**Other Comments:**

**Recommendations for Evaluation and Assessment:**



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**Form E**

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IFSP Date:

Name:

DOB:

Outcome #:

**Outcome/Action To Take**

**OUTCOME-** What would you like to see happen for your child/family?

**STRATEGIES-** Activities to be imbedded in daily routine of your child and family to achieve this outcome:

**RESOURCES-** People or resources that can help achieve this outcome:

**PROGRESS-** Timeline and criteria for determining progress/indicators of how the child's behavior/daily life in the family has improved:

**Natural Environment Justification:** Services/supports/strategies that have been used to try to achieve the outcome in Natural Environment?

How will the intervention be incorporated into daily routines and activities? Describe plans for ensuring that this outcome is addressed in the natural environment in the future (include a timeline).

**Progress Towards the Outcome:**

Date Reviewed:       Outcome reached       Continue outcome       Outcome Modified

Modifications:

I have received prior notice of the proposed new, changed or terminated services and understand the reason(s) for taking the action(s).

I have received a copy and explanation of my procedural safeguards.

\_\_\_\_\_ (Parent/Guardian Signature)      Date:

\_\_\_\_\_ (Signature) Role:      Date:

\_\_\_\_\_ (Signature) Role:      Date:

Date Reviewed:       Outcome reached       Continue outcome       Outcome Modified

Modifications:

I have received prior notice of the proposed new, changed or terminated services and understand the reason(s) for taking the action(s).

I have received a copy and explanation of my procedural safeguards.

\_\_\_\_\_ (Parent/Guardian Signature)      Date:

\_\_\_\_\_ (Signature) Role:      Date:

\_\_\_\_\_ (Signature) Role:      Date:

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**Form F**

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IFSP Date:

Name:

DOB:

**Summary of Services**

Part C Eligibility Criteria

Established Condition of:

Developmental Delay in the area(s) of:

**SUMMARY OF INFORMAL SUPPORTS TO PROMOTE THE ACHIEVEMENT OF OUTCOMES:**

**EARLY STEPS SERVICES**

Provider Information (Name/Agency)	Service Provider Role (primary service provider, consultant, etc)	Service	Location Code	Natural Environment	Payer of Service	Start Date	End Date	Related to Outcome Number	Frequency/ Intensity
				Y / N		Authorization Period			

**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**

**OTHER SERVICES:** These services may be helpful to your child and family, but are not covered under Part C. The identification of these will help the service coordinator and the IFSP Team to better assist you in coordinating all your services.

Outcome/Service	Activities/Steps Needed	Timeline	Provider Name/Agency Responsibility	Funding Source



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**Form H**

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IFSP Date:

Name:

DOB:

**YOUR INDIVIDUALIZED FAMILY SUPPORT PLAN TEAM:** The Team of people working with your family.

Printed Name	Position/ Role	Address	Telephone	IFSP Participants (Initial)	May receive Copy of IFSP (Family Initial)
	Parent/ Guardian				
	Parent/ Guardian				
	Service Coordinat or				
	Primary Service Provider				
	Primary Care Physician				

**I received the following:**  Copy of service provider options list     Explanation of procedure for requesting new Service Coordinator  
 Copy of Procedural Safeguards     Copy of Family Resource Specialist contact information     Copy of Early Steps brochure w/Central Directory phone number     Explanation of Early Steps Complaint Procedures     Copy of Individualized Family Support Plan

**Parent/Guardian Comments or Concerns:**

**I understand that signing the IFSP constitutes consent to begin services except as noted below.**

**Comments/concerns I wish to add:**

I helped write this plan, agree with it, and agree for services to be provided. I have received prior notice of any proposed new, changed or terminated services and understand the reason(s) for taking the action(s). I have been told what to do if I disagree with this plan. I have been given a copy of the procedural safeguards for Part C or Part B of IDEA, as appropriate, and these rights and safeguards have been explained. 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 Date

\_\_\_\_\_  
Signature Relationship Date

\_\_\_\_\_  
Signature Relationship Date