**Individualized Family Service Plan**



Under Part C of IDEA, the IFSP is required to enhance the capacity of families to

meet the needs of children birth to age three who have developmental delays or disabilities.

**Type and Date of IFSP: [ ]  Initial IFSP \_\_\_\_\_\_\_\_\_ [ ]  Annual IFSP \_\_\_\_\_\_\_\_**

 **[ ]  Interim IFSP \_\_\_\_\_\_\_\_ [ ]  IFSP Review \_\_\_\_\_\_\_\_**

**I. Child and Family Information**

|  |  |
| --- | --- |
| **Child's Name:**  |  |
| **Date of Birth:** |  | **Gender: [ ]  Male [ ]  Female**  |
| **Parent’s/Guardian’s Name(s):** |  | **Surrogate Parent: [ ]  Yes [ ]  No** |
| **Address(es):** |  |  |
|  |  |  |
| **City/State/Zip:** |  |  |
| **Phone Number(s):** | **( ) -**  **Work [ ]  Home [ ]  Cell [ ]** **( ) -**  **Work [ ]  Home [ ]  Cell [ ]** **( ) -**  **Work [ ]  Home [ ]  Cell [ ]**  | **( ) -** **Work [ ]  Home [ ]  Cell [ ]** **( ) -** **Work [ ]  Home [ ]  Cell [ ]** **( ) -** **Work [ ]  Home [ ]  Cell [ ]**  |
| **Email Address(es):** |  |  |
| **Ethnicity:** |  |
| **Family’s Primary Language:** |  | **Is an Interpreter Needed? [ ]  Yes [ ]  No** |
| **Resident School District:** |  |
| **Service Area:** |  |
| **Alternate contact:** |  |
| **Relationship to child:** |  |
| **Address:** |  |
|  |  |
| **City/State/Zip:** |  |
| **Phone Numbers:** | **( ) -** **( ) -****( ) -**  | **Work [ ]  Home [ ]  Cell [ ]** **Work [ ]  Home [ ]  Cell [ ]** **Work [ ]  Home [ ]  Cell [ ]**  |
| **Email Address:** |  |
| **Who lives in your home?** |
| **Describe previous developmental evaluations/assessments, early intervention and/or therapy services received (if any):** |

**Family Resources Coordinator’s Information**

|  |  |
| --- | --- |
| **Family Resources Coordinator's Name:**  |  |
| **Agency** |  |
| **Agency Address:** |  |
|  |  |
| **City/State/Zip** |  |
| **Phone Number:** | **( ) -**  | **Work [ ]  Cell [ ]**  |
| **Email Address:** |  |

**Referral and Medical/Health Information**

|  |
| --- |
| **Referral Information** |
| **Referral Date:** |  |
| **Reason for Referral:** |  |
| **Referral Source:** |  |
| **Address:** |  |
| **City/State/Zip** |  |
| **Phone Number: ( ) -**  | **Fax: ( ) -**  | **Email Address:**  |

|  |
| --- |
| **Primary Care Information** |
| **Primary Care Provider’s Name:** |  |
| **Address:** |  |
| **City/State/Zip** |  |
| **Phone Number: ( ) -**  | **Fax: ( ) -**  | **Email Address:**  |

|  |
| --- |
| **Child Health Information** |
| **Summary of child’s health status based on review of pertinent records** *(This is includes child’s birth history, medical conditions or diagnoses (i.e. allergies), illnesses, hospitalizations, medications, vision and hearing screenings, other developmental evaluations)****:*** |
| **What else should the team know about your child’s health so we can better plan and provide services for your child and family?**  |

**II. Child/Family Routines and Activities**

Understanding the routines and activities of children and families assists the team in identifying the numerous learning opportunities that can support children’s learning and development.

|  |
| --- |
| **Where does your child spend the day? Who is involved? How would you describe your child’s relationship(s) with you and the people they spend the most time with in different settings?** |
| **What are the things your child enjoys most (including toys, people, places, activities, etc.)?** |
| **What does your family enjoy doing together and why? Who is involved? When does this occur?** |
| **What activities and relationships are going well?** |
| **What, if any, routines and activities do you find to be difficult or frustrating for you or your child?** |
| **What are the activities and routines your family currently does not do because of your child’s needs, but is interested in doing now or in the near future?**  |

**Family Concerns, Resources, Priorities**

Family’s concerns and priorities drive the development of IFSP outcomes. Family resources and supports are critical for supporting and enhancing desired changes and children’s functioning and learning. Families should share only the information they are comfortable sharing.

I choose **not** to share information about my concerns, priorities and resources and/or include this information in the IFSP. I understand that if my child is eligible, he/she can still receive appropriate services as determined by the IFSP team even if I choose not to complete this section.

\_\_\_\_\_\_\_\_ (parent’s initials)

|  |
| --- |
| **Summary of Family Concerns:** *(based on challenges in everyday routines and activities)* |
| **Priorities of the Family:** *(based on concerns identified above)* |
| **Strengths, Resources that Family has to Meet their Child’s Needs:** *(include family, friends, community groups, financial supports, etc. that are helpful to you)* |
| **In addition to the information you have already provided, do you have any additional concerns that you have not yet shared, or that others have shared with you about your child? Is there anything else you like to tell us that would be helpful in planning supports and services with you to address what is most important to your child and family?** |

**III. Child’s Present Levels of Development**

Understanding a child’s skills, as identified through evaluation and assessment (including observations, parent report, testing), assists the team (including parents) in planning supports and services that enhance the child’s learning.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Developmental Area** | **Description of Skills/Status** *(list child’s skills in each developmental area/describe status; include information about sensory needs in each domain )* | **Developmental Level***(% of delay, standard deviation, age equivalent)* | **Information Source***(Instrument(s), Parent report, observation)* | **Evaluator’s Name and Evaluation/ Assessment Date** |
| **Adaptive** **Feeding, eating, dressing, sleeping***(ex., holds a bottle; reaches for toy, helps dress himself or herself)* |  |  |  |  |
| **Cognitive****Thinking and learning***(ex., looks for dropped toy; pulls toy on a string; does a simple puzzle)* |  |  |  |  |
| **Expressive Communication** **Making sounds, gesturing, talking***(ex., vocalizes vowels; points to objects to express wants; uses 2 or more words)* |  |  |  |  |
| **Receptive Communication** **Understanding words and gestures***(ex., looks when hears name; points to body parts and common objects when named; follows simple 1 & 2 step directions; understands simple words)* |  |  |  |  |
| **Physical: Fine Motor** **Using hands and fingers***(ex., reaches for and plays with toys; picks up raisin; strings beads)* |  |  |  |  |
| **Physical: Gross Motor** **Moving and using large muscles***(ex., rolls from tummy to back; sits independently; walks holding on)* |  |  |  |  |
| **Social/Emotional** **Interacting with others***(ex., smiles and shows joy; makes good eye contact; seeks help from familiar caregivers; takes turns; shares toys)* |  |  |  |  |
| **Vision***(ex., visually tracks object; attends to faces of familiar people; returns head to starting point when watching slowly disappearing object)* |  |  |  |
| **Hearing***(ex., turns head, smiles, or acts in response to voices and, sounds; responds to name)* |  |  |  |

**Initial Eligibility for Part C Services**

The evaluation and assessment of each child and the determination of the child’s initial eligibility for Part C

early intervention services must include the use of informed clinical opinion. Eligibility determination is a team decision.

|  |
| --- |
| [ ]  Your child is eligible for Part C Services because he/she has *(check one or more below)*: |
| [ ]  A 1.5 standard deviation or 25% delay in development in one or more areas *(check all that apply)*:  [ ]  Cognitive [ ]  Physical: fine motor [ ]  Physical: gross motor[ ]  Adaptive  [ ]  Social or emotional [ ]  Expressive Communication [ ]  Receptive Communication  |
| [ ]  A diagnosed condition that is likely to result in delay in development (*identify*):  |
| [ ]  Informed Clinical Opinion (*check and provide explanation if this is the only method used for determining eligibility although clinical opinion must be used throughout evaluation and assessment*):  |

 **Ongoing Eligibility for Part C Services**

The evaluation and assessment of each child and the determination of the child’s ongoing eligibility for Part C

early intervention services must include the use of informed clinical opinion. Eligibility determination is a team decision.

|  |
| --- |
| [ ]  Your child continues to be eligible for Part C Services based upon their present levels of development and/or diagnosed condition. |

**Summary of Functional Performance**

Summarizing how a child uses skills in various domains to function across settings and situations provides information that assists the team (including the parents) in developing functional IFSP outcomes and strategies to meet these outcomes and so progress can be monitored over time. This information also assists in the completion of the Child Outcomes Summary information.

|  |
| --- |
| **Positive Social/Emotional Skills (including social relationships):** (*relating with adults; relating with other children; following rules related to groups or interacting with others)* |
|  Summary of Child’s Functioning: |
|  Outcome Descriptor Statement (Select one): |

|  |
| --- |
| **Acquiring and Using Knowledge and Skills (including early language/communication):** *(thinking, reasoning, remembering and problem solving; understanding symbols, understanding the physical and social worlds)* |
|  Summary of Child’s Functioning: |
|  Outcome Descriptor Statement (Select one): |

|  |
| --- |
| **Use of Appropriate Behaviors to Meet their Needs:** *(taking care of basic needs, e.g. showing hunger, dressing, feeding, toileting, etc.; contributing to own health and safety, e.g., follows rules, assists with hand washing, avoids inedible objects (if over 24 months); getting from place to place (mobility) and using tools (e.g., forks, strings attached to objects, etc.))* |
|  Summary of Child’s Functioning: |
|  Outcome Descriptor Statement (Select one): |

**Date child outcomes descriptor statements were selected by the team: \_\_\_/\_\_\_/\_\_\_**

**Assessment Team**

|  |
| --- |
| **The following individuals participated in the evaluation and assessment:** |
| *Printed name and Credentials* | *Role/organization* | *Assessment Activities* |
|  |  | **[ ]** Child’s Present Levels of Development[ ]  Eligibility for Part C Services[ ]  Contributed information for Summary of Functional Performance[ ]  Participated in selection of Outcomes Descriptor Statements |
|  |  | **[ ]** Child’s Present Levels of Development[ ]  Eligibility for Part C Services[ ]  Contributed information for Summary of Functional Performance[ ]  Participated in selection of Outcomes Descriptor Statements |
|  |  | **[ ]** Child’s Present Levels of Development[ ]  Eligibility for Part C Services[ ]  Contributed information for Summary of Functional Performance[ ]  Participated in selection of Outcomes Descriptor Statements |
|  |  | **[ ]** Child’s Present Levels of Development[ ]  Eligibility for Part C Services[ ]  Contributed information for Summary of Functional Performance[ ]  Participated in selection of Outcomes Descriptor Statements |
|  |  | **[ ]** Child’s Present Levels of Development[ ]  Eligibility for Part C Services[ ]  Contributed information for Summary of Functional Performance[ ]  Participated in selection of Outcomes Descriptor Statements |

|  |
| --- |
| **Family role in Child Outcomes Summary process** *(check only one):* \_\_\_ Family was present for the discussion *and* the selection of the descriptor statements  \_\_\_ Family was present for the discussion, but not the selection of the descriptor statements \_\_\_ Family provided information, but was not present for the discussion |

|  |
| --- |
| **Family information on child functioning** *(check all that apply):*\_\_\_ Received in team meeting \_\_\_ Collected separately \_\_\_Incorporated into assessment \_\_\_ Not included (Please explain :) |

|  |
| --- |
| **Assessment instruments informing child outcomes summary:** **Other sources of information** *(e.g., practitioner observation; information from child care provider)***:**  |

**IV. Functional IFSP Outcomes for Children and Families**

Functional outcomes must reflect the changes families would like to see happen for themselves and their children and be based on family priorities and the developmental needs of the child.

|  |
| --- |
| **Outcome # \_\_\_\_\_ Start Date: \_\_\_\_\_\_\_\_\_\_\_** **Target Date: \_\_\_\_\_\_\_\_\_\_\_** |
| **What would your family like to see happen for your child/family?** *(The outcome must be functional, measurable and in the context everyday routines and activities.)* |
| **What’s happening now related to this outcome? What is your family currently doing that supports achieving this outcome?** *(Describe your child and/or family’s functioning related to the desired change/outcome.)* |
| **What are the ways in which your family and team will work toward achieving this outcome? Who will help and what will they do?** *(Describe the methods and strategies that will be used to support your child and family to achieve your outcomes within your daily activities and routines. List who will do what including both early intervention services and informal supports, including family members, friends, neighbors, church or other community organizations, special health care programs, parent education programs.)* |
| **How will we know we’ve made progress or if revisions are needed to outcomes or services?** *(What criteria [i.e., observable action or behavior that show progress is being made], procedures [i.e., observation, report, chart], and realistic timelines will be used?)*  |
| **How did we do?** *(Review of progress statement/Criteria for Success)* Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Achieved: We did it!Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Continue: We are part way there. Let’s keep going.**The situation has changed:**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Discontinue: It no longer applies.Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Revise: Let’s try something different.**Date: \_\_\_\_\_\_\_\_\_\_\_Explanations/Comments:** |

**Functional IFSP Outcomes Supported by the Family Resources Coordinator**

**Related to Accessing Community Resources and Supports**

Family Resources Coordination is provided to all families enrolled in early intervention services. A Family Resources Coordinator will help you identify and access community resources and supports that you or your child may need, based on your current priorities. This page outlines the steps and activities that you and your team will take to connect you with these resources.

|  |
| --- |
| **Outcome # \_\_\_ What do we want to accomplish?** *(Desired Outcome)* **Start Date: \_\_\_\_\_\_\_\_\_\_\_** **Target Date: \_\_\_\_\_\_\_\_\_\_\_** |
| **Who will do what?** *(Strategies/Activities)***Review Date: \_\_\_\_\_\_\_\_\_\_\_\_****Progress Code (circle one):** Achieved Continue Discontinue Revise**Comments:** |
| **Outcome # \_\_\_ What do we want to accomplish?** *(Desired Outcome)* **Start Date: \_\_\_\_\_\_\_\_\_\_\_\_** **Target Date: \_\_\_\_\_\_\_\_\_\_\_** |
| **Who will do what? (Strategies/Activities)****Review Date: \_\_\_\_\_\_\_\_\_\_\_\_****Progress Code (circle one):** Achieved Continue Discontinue Revise**Comments:** |
| **Outcome # \_\_\_ What do we want to accomplish?** *(Desired Outcome)* **Start Date: \_\_\_\_\_\_\_\_\_\_\_\_** **Target Date: \_\_\_\_\_\_\_\_\_\_\_** |
| **Who will do what? (Strategies/Activities)****Review Date: \_\_\_\_\_\_\_\_\_\_\_\_****Progress Code (circle one):** Achieved Continue Discontinue Revise**Comments:** |

**V. Transition Planning**

The Transition Plan outlines steps and activities to support children and families leaving early intervention

 and transitioning to other community or school services.

|  |
| --- |
| **Priorities and goals for your child’s transition:** |
|  |

|  |
| --- |
| **Early Childhood Special Education Contact Information** |
| **Early Childhood Special Education Contact’s Name:** |  |
| **Phone Number: ( ) -**  | **Work [ ]  Cell [ ]**  | **Email Address:**  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Transition Planning Requirements and Activities** | **Action Steps** | **Role of Person Responsible** | **Date Initiated** | **Date Completed** |
| 1. Discuss with parents what “transition” from early intervention means, including eligibility and age guidelines for early intervention services and what can be done to plan for this transition.
 |  |  |  |  |
| 1. Discuss with parents possible program options (including preschool special education services; Head Start; child care and other community services) that may be available when child is no longer eligible.
 |  |  |  |  |
| 1. Provide LEA notification that the child is potentially eligible for Part B services (including child’s name, address, phone number and date of birth.)
 |  |  |  |  |
| 1. Provide opportunity for parents to meet and receive information from the local education agency or other community program representatives as appropriate.
 |  |  |  |  |
| 1. Establish procedures to prepare the child for changes in service delivery, including steps to help the child adjust to and function in a new setting (i.e. visit the new program, meet with program staff prior to the child’s first day, help family secure materials and supplies that will be needed (such as a back pack.)
 |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Transition Planning Requirements and Activities** | **Action Steps** | **Role of Person Responsible** | **Date Initiated** | **Date Completed** |
| 1. With parental consent, transfer records information (including evaluation and assessments and the IFSP).
 |  |  |  |  |
| 1. Assist parents to understand their rights and to develop advocacy skills.
 |  |  |  |  |
| 1. With parental agreement, schedule the transition conference (at least 90 days before the child’s third birthday) and invite participants including parents, early intervention personnel, local education agency, Head Start, and other community providers as appropriate.
 |  |  |  |  |
| 1. At the transition conference:
 |  |  |  |  |
| * 1. Decide what other activities need to be completed before the child moves into the new service setting (including enrollment; immunizations; transportation issues, medical needs etc.).
 |  |  |  |  |
| * 1. Review current evaluation and assessment information. Decide if any further evaluations are needed to determine eligibility to Part B or other programs prior to transition.
 |  |  |  |  |
| * 1. As appropriate, schedule IEP meeting date if the child will transition into preschool special education.
 |  |  |  |  |
| * 1. If the child is transitioning to Part B, review with parents the program options for their child from the child’s third birthday through the remainder of the school year.
 |  |  |  |  |
| * 1. Decide if there is a need for post transition follow-up (including service coordination, consultation with new staff).
 |  |  |  |  |
| 10.Other transition planning activities: |  |  |  |  |

 **VI. Summary of Services**

Services and supports are determined following the development of functional IFSP outcomes. They are

designed to enhance the capacity of the family in supporting their child’s development and to

 promote the child’s learning and development through functional participation in family and community activities.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Early****Intervention****Services** | **Outcome #****(list all that apply)** | **Frequency/Intensity**  | **Methods** | **Setting** | **Natural Environment****Y/N\*** | **Payment Arrangements**(if any) | **Start Date** | **End Date** | **Agency(ies)****Responsible** |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| **Documentation of discussions to reach consensus about services:** *(Include discussions about any services refused or declined, as well as any negotiations about frequency, intensity or method of service delivery, i.e., Discussed parents’ priority to work on feeding now and wait for motor outcomes until later; Discussed team recommendation for 24 one hour visits for the next 12 weeks, parent only wanted 12 one hour visits for the next 12 weeks.)* |

\* If setting is not a natural environment, complete the justification.

**Other Services**

These are additional services that your child and family are currently accessing, but are not entitled under Part C. Such additional services may include medical services such as well-baby checks, follow-up with specialists for medical purposes, etc.

| **Do you or your child currently receive any of the following services?** |
| --- |
|  **Check if applicable** | **Financial & Other Basic Assistance** |  **Check if applicable** | **Health and Medical****Services** |  **Check if applicable** | **General Services** |
|  | Medicaid/Apple Health – child |  | WIC Nutrition Program |  | Early Head Start or Head Start |
|  | Medicaid/Basic Health – parent |  | First Steps |  | Migrant Head Start – American Indian/Alaska Native Head Start |
|  | Health Insurance - child |  | Immunizations (Baby Shots) |  | Child Care |
|  | Health Insurance - parent |  | Family Planning Clinic |  | Home Visiting |
|  | Medicaid Premium Payment Program |  | Well Child Care |  | Division of Developmental Disabilities (DDD, non-EIS services) |
|  | Food Stamps |  | Children with Special Health Care Needs Program |  | Preschool |
|  | Financial Assistance |  | Primary care - parent |  | Other general services:  |
|  | SSI |  | Medical specialists (i.e. cardiology, neurology, etc.) |  | Parent to Parent (P2P) referral |
|  | Child Care subsidies |  | EPSDT/Medicaid Health Check |  | Washington State Fathers Network (WSFN) referral |
|  | TANF |  | Dental care |  |  |
|  | Other financial services:  |  | Indian Health Services |  |  |
|  |  |  | Other health services:  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **Comments** (include names, contact information and funding sources for above services as appropriate): |

|  |
| --- |
| **What other services do your child and family need, and want to access?**  |
| Other Service | **Provider** | **Steps to be Taken to Help Family Access These Services or Funding Sources to be Used**  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**VII. Natural Environment Justification**

Children learn best through natural learning opportunities that occur in settings where the child and family normally participate. Early intervention supports and services must be provided in settings that are natural or typical for children

 of the same age (i.e., natural environments). If the team decides that the outcome cannot be achieved

in a natural environment, a justification must be provided including why that decision was made and what

we will do to move services and supports into natural environments as soon as possible.

|  |  |  |
| --- | --- | --- |
| **Outcome #** | **Service(s)/Support(s)** | **Setting****(Non-Natural Environment Setting Where Service(s)/Support(s) Will be Provided)** |
|  |  |  |
| **Explanation of Why Outcome Cannot be Achieved in a Natural Environment:** |
| **Plan for Moving Service(s) and/or Support(s) into Natural Environments:** |

**VIII. IFSP Agreement**

|  |
| --- |
| **Written Prior Notice and Parental Consent for Provision of Early Intervention Services** |
| **Written Prior Notice:**Written prior notice must be provided to parents of an eligible child a reasonable time before the program proposes or refuses to initiate or change the identification, evaluation or placement of the child or the provision of appropriate early intervention service to the child and the child’s family. **Action Proposed:**To initiate the services listed on the IFSP for which consent is provided, according to the Summary of Services.**Reasons for Taking the Action**:After discussing all assessment information, including family observations and their concerns, priorities and resources, the IFSP team, including the family, agreed on the early intervention services and other supports to be provided to achieve desired outcomes.**Action Refused (if any):****Reasons for Refusal (if action refused):****Consent:**I participated in the development of this IFSP and I give informed consent for the Washington *Early Support for Infants and Toddlers* program and service providers to carry out the activities listed on this IFSP. Consent means I have been fully informed of all information about the activities 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 activities for which consent is sought; the consent describes the activities and lists of records (if any) that will be released and to whom; and the granting of my consent is voluntary and may be revoked in writing at any time. I understand that I may accept or decline any early intervention service (except the required procedural functions under the regulations for Family Resources Coordination) and may decline such a service after first accepting it without jeopardizing any other early intervention service(s) my child or family receives through the Washington *Early Support for Infants and Toddlers* program. (NOTE: Complete the *Declining One or More Early Intervention Services* or *Declining Participation in the ESIT Program* formif appropriate*.*)I understand that my IFSP will be shared among the early intervention providers and program administrators responsible for implementing this IFSP.I have received a copy of Washington *Early Support for Infants and Toddlers* program*, Individuals with Disabilities Education Act (IDEA) Part C Procedural Safeguards [Parent Rights]* along with this IFSP. This information includes the complaint procedures and timelines I may use if I decide later that I disagree with any decisions. These rights have been explained to me and I understand them. |
| Signature(s) of  *(check one)*: [ ] Parent(s) [ ] Legal Guardian [ ]  Surrogate Parent | Date |

|  |
| --- |
| **IFSP Participants** **that attended the IFSP Meeting:** *Printed name and Credentials Role/organization Signature Date* |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

|  |
| --- |
| **The following individuals did not attend the meeting but participated in the meeting through conference call or in writing** (*specify which*):*Printed name and Credentials Role/organization Conference Call/In Writing* |
|  |
|  |
|  |

**IX. IFSP Review**

The IFSP is a fluid, flexible document that can be updated as you or your child’s and family’s needs change. Reviews of the IFSP must occur every six months, and additional reviews can be held whenever changes are needed to the IFSP. This page will summarize the changes being made to your child’s IFSP at each review.

|  |
| --- |
| **Date of Review: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Summary of Review Results** *(i.e., progress made towards outcomes or new outcomes developed; changes in the family’s concerns, resources and priorities; changes to service provision; plans until next review, etc)***.** *Any changes to services and outcomes noted in this review must also be updated in the appropriate section of the current IFSP.* |
|  |

**IFSP Review Agreement**

|  |
| --- |
| **Written Prior Notice and Parental Consent for Provision of Early Intervention Services** |
| **Written Prior Notice:**Written prior notice must be provided to parents of an eligible child a reasonable time before the program proposes or refuses to initiate or change the identification, evaluation or placement of the child or the provision of appropriate early intervention service to the child and the child’s family. **Action Proposed:**To initiate the services listed on the IFSP for which consent is provided, according to the Summary of Services.**Reasons for Taking the Action**:After discussing all assessment information, including family observations and their concerns, priorities and resources, the IFSP team, including the family, agreed on the early intervention services and other supports to be provided to achieve desired outcomes.**Action Refused (if any):****Reasons for Refusal (if action refused):****Consent:**I participated in the development of this IFSP and I give informed consent for the Washington *Early Support for Infants and Toddlers* program and service providers to carry out the activities listed on this IFSP. Consent means I have been fully informed of all information about the activities 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 activities for which consent is sought; the consent describes the activities and lists of records (if any) that will be released and to whom; and the granting of my consent is voluntary and may be revoked in writing at any time. I understand that I may accept or decline any early intervention service (except the required procedural functions under the regulations for Family Resources Coordination) and may decline such a service after first accepting it without jeopardizing any other early intervention service(s) my child or family receives through the Washington *Early Support for Infants and Toddlers* program. (NOTE: Complete the *Declining One or More Early Intervention Services* or *Declining Participation in the ESIT Program* formif appropriate*.*)I understand that my IFSP will be shared among the early intervention providers and program administrators responsible for implementing this IFSP.I have received a copy of Washington *Early Support for Infants and Toddlers* program*, Individuals with Disabilities Education Act (IDEA) Part C Procedural Safeguards [Parent Rights]* along with this IFSP. This information includes the complaint procedures and timelines I may use if I decide later that I disagree with any decisions. These rights have been explained to me and I understand them. |
| Signature(s) of  *(check one)*: [ ] Parent(s) [ ] Legal Guardian [ ]  Surrogate Parent | Date |

|  |
| --- |
| **IFSP Participants** **that attended the IFSP Meeting:** *Printed name and Credentials Role/organization Signature Date* |
|  |
|  |
|  |
|  |
|  |

|  |
| --- |
| **The following individuals did not attend the meeting but participated in the meeting through conference call or in writing** (*specify which*):*Printed name and Credentials Role/organization Conference Call/In Writing* |
|  |
|  |
|  |