

MARYLAND INFANTS AND TODDLERS PROGRAM

Individualized Family Service Plan (IFSP)

Referral Date:	IFSP Meeting Date:	IFSP Meeting Type: <input type="checkbox"/> Interim <input type="checkbox"/> Initial <input type="checkbox"/> Annual Evaluation
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Child and Family Information

Child Name (First/Middle/Last):		
Birth Date:	ID Number:	MA Number:
Address:		Home Phone:
Parent/Guardian/Surrogate Name:		
Address:		Home Phone:
Address:		Work Phone:
E-mail:		Cell Phone:
Best Time to Contact:	Best Method of Contact: <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> E-mail	

Team Participant Signatures

Each agency or person who has a direct role in the provision of early intervention services is responsible for assisting the eligible child and family to achieve the outcomes in this IFSP.

<i>Service Coordinator</i>	<i>Date</i>	<i>Evaluator/Assessor (or involvement through other means, as appropriate)</i>	<i>Date</i>
<i>Interim/Alternate Service Coordinator</i>	<i>Date</i>	<i>Other Participant</i>	<i>Agency/Title</i> <i>Date</i>
<i>Lead Agency Representative</i>	<i>Date</i>	<i>Other Participant</i>	<i>Agency/Title</i> <i>Date</i>
<i>Parent(s)/Guardian/Surrogate</i>	<i>Date</i>	<i>Other Participant</i>	<i>Agency/Title</i> <i>Date</i>

Service Coordinator Information

If you have questions about this IFSP or any of the individuals working with your child and family, contact your service coordinator.

Service Coordinator Name:	
Agency:	
Address:	
Work Phone:	E-mail:

Projected IFSP Meeting Dates

Projected Date Six Month IFSP Review:
Projected Date Annual IFSP Review Date:
Projected Date Range Transition Planning Meeting:

Child Name:	ID Number:	IFSP Meeting Date:
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PART I - INFORMATION ABOUT MY CHILD'S DEVELOPMENT
Section A - Health Information

General Health

What was your child's gestational age at birth? _____ Weeks _____ Days
What was your child's birth weight? _____ Pounds _____ Ounces <u>OR</u> _____ Grams
Who is your primary care physician or other health care professional? _____ Phone: _____

IMMUNIZATIONS

Do you have a copy of your child's immunization record? Yes No
If NO, please indicate the strategies to be used to obtain a copy of your child's immunization record.

Does the immunization record have the required immunizations for your child's chronological age? Yes No
If NO, what strategies will be implemented for your child to receive the required immunizations?

Indicate immunizations received (*immunizations in **BOLD** are required for public school*):
 DTaP/DT **Polio** **Hib** **HepB** **PCV7** Rotavirus MCV4 Hep A **MMR** **Varicella**

Indicate immunizations needed (*immunizations in **BOLD** are required for public school*):
 DTaP/DT **Polio** **Hib** **HepB** **PCV7** Rotavirus MCV4 Hep A **MMR** **Varicella**

LEAD SCREENING/TESTING

Has your child's lead level been tested? Yes No If **YES**, what was the level? _____

Are there any concerns about your child's lead level? Yes No If **YES**, please explain. _____

NUTRITION

Are there any concerns about your child's eating, general nutrition or growth? Yes No
If YES, please explain.

GENERAL HEALTH CONCERNS

Is there anything about your child's health (special equipment, allergies, other mental or physical information) that the team should know about to better plan and provide services to your child and family?

Child Name:	ID Number:	IFSP Meeting Date:
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PART I - INFORMATION ABOUT MY CHILD'S DEVELOPMENT
Section B - Present Levels of Development

Evaluation Status:	<input type="checkbox"/> Entry <input type="checkbox"/> Interim (Birth to 3) <input type="checkbox"/> Exit (Birth to 3) <input type="checkbox"/> Interim (3 to Kindergarten Age) <input type="checkbox"/> Exit (3 to Kindergarten Age)
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Present Levels of Development

Area	Date of Assessment (MM/DD/YY)	Name of Assessment Instrument(s)	Chronological Age	Age Level/ Age Range	Qualitative Description
Cognitive (Playing, thinking and exploring)					
Communication (Understanding others and expressing myself)					
Social or Emotional (Emotions, feelings, and interacting with others)					
Adaptive (Eating, drinking, toileting, and doing things for myself)					
Physical					
Fine Motor (Using my hands for play, feeding or other activity)					
Gross Motor (Moving my body to change position or location)					
Hearing	Did your child pass a Universal Newborn Hearing Screening? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable Has your child seen an audiologist for a full hearing evaluation? <input type="checkbox"/> Yes <input type="checkbox"/> No Are there any concerns about your child's hearing? <input type="checkbox"/> Yes <input type="checkbox"/> No Results of Evaluation/Observation:				
Vision	Has your child's vision been tested? <input type="checkbox"/> Yes <input type="checkbox"/> No Are there any concerns about your child's vision? <input type="checkbox"/> Yes <input type="checkbox"/> No Results of Evaluation/Observation:				

PART I - INFORMATION ABOUT MY CHILD'S DEVELOPMENT
Section C - Eligibility for Early Intervention Services

Eligibility

Your child is eligible for early intervention services based upon the results of the evaluation process. Eligibility is based on the ONE category that is checked below.

 AT LEAST A 25% DEVELOPMENTAL DELAY

My child is eligible for early intervention services because my child is experiencing at least a 25% delay in one or more of the following developmental areas. **Check all that apply:**

- Cognitive
 Communication
 Social or Emotional
 Adaptive
 Physical: ___ Fine Motor ___ Gross Motor

 ATYPICAL DEVELOPMENT OR BEHAVIOR

My child is eligible for early intervention services because my child is demonstrating atypical development or behavior in one or more of the following developmental areas, that is likely to result in a subsequent delay. **Check all that apply:**

- Cognitive
 Communication
 Social or Emotional
 Adaptive
 Physical: ___ Fine Motor ___ Gross Motor

 DIAGNOSED PHYSICAL OR MENTAL CONDITION WITH A HIGH PROBABILITY OF DEVELOPMENTAL DELAY

My child is eligible for early intervention services because my child has a diagnosed physical or mental condition that has a high probability of resulting in developmental delay. This list is not all-inclusive. **Check all that apply:**

- Chromosomal disorder: ___ Down Syndrome ___ Other: _____
 Chronic lung disease (CLD)
 Congenital infection that is symptomatic (e.g., HIV)
 Inborn errors of metabolism associated with CNS involvement (e.g., maple syrup urine disease and galactosemia)
 Infants showing significant effects of maternal prenatal alcohol abuse (e.g., Fetal Alcohol Syndrome)
 Infants affected by intrauterine drug exposure requiring treatment or showing evidence of intrauterine growth restriction
 Intraventricular hemorrhage - Grades III or IV
 Lead poisoning, with a lead level of 20 ug/dL or greater
 Moderate to severe encephalopathy resulting from insult to the brain
 Neurodegenerative disorders with onset in infancy and early childhood (e.g., adrenoleukodystrophy, TaySachs disease)
 Periventricular Leukomalacia (PVL)
 Prematurity with birth weight of less than 1200 grams (2 lbs. 10 oz.)
 Seizure disorder where seizures are frequent or difficult to control or the underlying condition is associated with frequent cognitive impairment (e.g., infantile spasms)
 Sensory impairments
 - Blind or visually impaired
 - Deaf or hard of hearing Severe congenital malformations (e.g., meningomyelocele and congenital hydrocephalus)
 Surgical Necrotizing Enterocolitis (NEC)
 Other: _____
 Other: _____
 Other: _____

PART II - INFORMATION ABOUT MY FAMILY
Section A - Concerns, Priorities, and Resources

Concerns, Priorities, and Resources

To best support your child and family, it is helpful to know about issues and concerns that are important to your family. Your family's concerns, priorities, and resources will be used as the basis for developing outcomes and identifying strategies and activities to address the needs of your child and family. You may share as much or as little information as you choose.

MY FAMILY'S CONCERNS	MY FAMILY'S PRIORITIES	MY FAMILY'S RESOURCES
Concerns I have about my child's health and development. Information, resources, supports I need or want for my child and/or family.	My hopes and dreams for my child. The most important things for my child and/or family right now.	Resources that my child/family has for support, including people, activities, programs/organizations.

This information was gathered through a family-directed assessment using the following. **Check all that apply:**

<input type="checkbox"/> Locally developed family interview tool	<input type="checkbox"/> Ages and Stages Questionnaire (ASQ)
<input type="checkbox"/> Routines-Based Interview (RBI)	<input type="checkbox"/> Other tools/methods: _____

Family declined family-directed assessment.

PART II - INFORMATION ABOUT MY FAMILY
Section B - Natural Environments

Routines In Natural Environments

Early intervention services are provided in natural environments. A natural environment is a location where your child and family spend time, such as in the home, child care program, or other community setting. Natural environments are where typically developing children play and learn. The information below will help us determine the natural environment(s) in which your child and family will receive early intervention services.

Where does your child/family spend time? Check all that apply:

- | | | |
|---|--|--|
| <input type="checkbox"/> Child's home
<input type="checkbox"/> Child care center
<input type="checkbox"/> Religious setting
<input type="checkbox"/> Family child care | <input type="checkbox"/> Early Head Start/Head Start
<input type="checkbox"/> Library
<input type="checkbox"/> Home of family member
<input type="checkbox"/> Toddler playgroup
<input type="checkbox"/> Judy Center | <input type="checkbox"/> Family Support Center
<input type="checkbox"/> Parent's place of employment
<input type="checkbox"/> Shelter
<input type="checkbox"/> Other: _____ |
|---|--|--|

What are some of the activities that you like to do together as a family?

Is there something you would like to do as a family, but cannot do at this time?

What are the daily routines of your child and family? Are some of these routines challenging? Are there other routines that your family would like to establish?

What are the barriers that keep your child and family from participating in your daily routines and activities?

How can the program best support your family in its desire to improve or create important routines?

PART III - MY CHILD/FAMILY OUTCOMES RELATED TO MY CHILD'S DEVELOPMENT
Section A - Strengths and Needs Summary

Strengths and Needs Summary

For children to be active and successful participants at home, in the community, and in places like child care or preschool programs, they need to develop skills in three functional areas: (1) developing positive social-emotional skills; (2) acquiring and using knowledge and skills; and (3) taking appropriate action to meet needs. We use information about your child's present levels of development, your family's concerns, resources and priorities, and your daily routines to understand your child's individual progress in relation to him/herself and to same age peers. This information supports the development of meaningful outcomes for your child and family.

HOW DOES MY CHILD...		MY CHILD'S STRENGTHS	MY CHILD'S NEEDS	HOW DOES MY CHILD'S DEVELOPMENT RELATE TO HIS/HER SAME-AGE PEERS?
DEVELOPING POSITIVE SOCIAL-EMOTIONAL SKILLS	<ul style="list-style-type: none"> • Attend to people? • Relate with family members? • Relate with other adults? • Relate with other children? • Display emotions? • Respond to touch? 	What are some things my child likes to do? What skills does my child demonstrate or is beginning to demonstrate?	What are some skills or behaviors that my child does not do or are difficult for my child? In what activities or skill areas does my child need considerable support and/or practice?	<p>Has my child shown any new skills or behaviors related to positive social-emotional development since the last <i>Strengths and Needs Summary</i>?</p> <p><input type="checkbox"/> Yes (include as "Strengths") <input type="checkbox"/> No <input type="checkbox"/> Not applicable</p>
ACQUIRING AND USING KNOWLEDGE AND SKILLS	<ul style="list-style-type: none"> • Understand and respond to directions and/or requests from others? • Think, remember, reason and problem solve? • Interact with books, pictures, and print? • Understand basic concepts such as "more", "big", "hot"? 			<p>Has my child shown any new skills or behaviors related to acquiring and using knowledge and skills since the last <i>Strengths and Needs Summary</i>?</p> <p><input type="checkbox"/> Yes (include as "Strengths") <input type="checkbox"/> No <input type="checkbox"/> Not applicable</p>
TAKING APPROPRIATE ACTION TO MEET NEEDS	<ul style="list-style-type: none"> • Take care of his/her basic needs, such as feeding and dressing? • Move his/her body from place to place? • Use his/her hands to play with toys and use crayons? • Communicate wants and needs? • Contribute to his/her own health & safety? 			<p>Has my child shown any new skills or behaviors related to taking actions to meet needs since the last <i>Strengths and Needs Summary</i>?</p> <p><input type="checkbox"/> Yes (include as "Strengths") <input type="checkbox"/> No <input type="checkbox"/> Not applicable</p>
OTHER				

PART IV - MY CHILD'S EARLY INTERVENTION SERVICES

Early Intervention Services

Early intervention services enhance the development of your child and the capacity of your family to meet the needs of your child. Each early intervention service supports your individual child and family outcomes. A separate "Early Intervention Services" form is completed for each service/support/setting.

TYPE OF SERVICE	SERVICE DESCRIPTION				SETTING
	Number of Sessions	Frequency	Intensity	Method	
Please specify:	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> Other: _____	<input type="checkbox"/> Only <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually	<i>Number of minutes per session:</i> <input type="checkbox"/> 15 <input type="checkbox"/> 30 <input type="checkbox"/> 45 <input type="checkbox"/> 50 <input type="checkbox"/> 60 <input type="checkbox"/> 90 <input type="checkbox"/> 120 <input type="checkbox"/> 180 <input type="checkbox"/> 240 <input type="checkbox"/> Other: _____	<input type="checkbox"/> Group <input type="checkbox"/> Individual	<input type="checkbox"/> Home (<i>Principal residence of child's family or caregivers</i>) <input type="checkbox"/> Community-Based Setting (<i>Please specify:</i>) _____ <input type="checkbox"/> Other (<i>Please specify:</i>) _____ Justification for Other Setting: _____
Discussion of Early Intervention Service Delivery: _____					

Type of Service	Community-Based Settings <i>(Where children without disabilities are typically found)</i>	Other Settings <i>(Not community or home-based)</i>
<ul style="list-style-type: none"> • Audiology • Family Counseling Training • Health • Medical (diagnosis & evaluation only) • Nursing • Nutrition • Occupational Therapy • Physical Therapy 	<ul style="list-style-type: none"> • Psychological • Respite Care • Social Work • Special Instruction • Speech/Language Therapy • Vision Services • Other 	<ul style="list-style-type: none"> • Child care center (including family day care) • Preschool program • Regular nursery school • Early childhood center • Early Head Start/Head Start • Even Start • Judy Center • Library

Financial Responsibility: Check one agency responsible for payment of services. <input type="checkbox"/> Local School System <input type="checkbox"/> Local Health Department <input type="checkbox"/> Local Department of Social Service <input type="checkbox"/> Other (Please specify): _____	Provider Agency: Record the name of the agency providing the service. Use the standard text designation within each agency. _____ _____
Reimbursement Source: Check one reimbursement source <i>only</i> when the agency designated as financially responsible intends to request payment for the service from another source. <input type="checkbox"/> Medical Assistance <input type="checkbox"/> Maryland School for the Blind <input type="checkbox"/> Maryland School for the Deaf <input type="checkbox"/> Other (Please specify): _____	Provider Name/Phone Number: Record the name and phone number of the individual providing the service. _____ _____

Projected Service Initiation Date: Record the date on which the service is projected to begin. _____ <p align="center">MM/DD/YY</p>	Projected Service Review Date: Record the projected date on which the service will be reviewed. _____ <p align="center">MM/DD/YY</p>
Projected Duration: Record the time period that the service will be provided. _____ <p align="center">MM/YY</p>	Service Ending Date: Record the date on which the service ends. _____ <p align="center">MM/DD/YY</p>

PART IV CONTINUED - MY CHILD'S EARLY INTERVENTION SERVICES

Early Intervention Services (continued)

ASSISTIVE TECHNOLOGY

Does my child need assistive technology services or devices to increase, maintain, or improve his/her functional capabilities? Yes No

Types of Assistive Technology. Check *all* that apply:

- Activities of Daily Living (ADL)
- Adaptive Computer Hardware
- Adaptive Computer Software
- Auditory Aids
- Augmentative and Alternative Communication Device (AAC)
- Environmental Control Units (ECUs)
- Mobility Aids
- Play, Recreation, and Leisure Aids
- Seating and Positioning
- Transportation/Safety Aids
- Vision Aids
- Other _____

Provider

Provider Name:

Phone:	E-mail:
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TRANSPORTATION

Does this plan include the transportation necessary to enable my child and/or family to receive early intervention services? Yes No

Types of Transportation:

- | | |
|--|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Parent with reimbursement <input type="checkbox"/> School Bus <input type="checkbox"/> Cab/Taxi | <ul style="list-style-type: none"> <input type="checkbox"/> Public Transportation with reimbursement <input type="checkbox"/> Other (Please Specify) _____ |
|--|--|

Is any special equipment needed for transporting my child? Yes No
 If **YES**, specify the type of equipment: _____

Provider

Provider Name:

Phone:	E-mail:
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Child Name:	ID Number:	IFSP Meeting Date:
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PART V - SERVICE LINKAGES

Service Linkages

Service linkages are community services and supports designed to enhance your child's development and your family's capacity to meet the needs of your child and family. A separate "Service Linkages" form is completed for each family member.

Service linkages are being provided for the following family member. (Check only ONE of the following.)

- Eligible Child
 Sibling
 Family
 Parent/Guardian
 Other Relative

SERVICE LINKAGES TO BE PROVIDED (Check ALL that apply.)

<p>Child Care/Enrichment</p> <input type="checkbox"/> Before/After Child Care <input type="checkbox"/> Camps, Day/Residential <input type="checkbox"/> Early Head Start/Head Start <input type="checkbox"/> Even Start <input type="checkbox"/> Family Day Care <input type="checkbox"/> Group Child Care Centers <input type="checkbox"/> In-home Child Care <input type="checkbox"/> Preschool Program <input type="checkbox"/> Tutoring <input type="checkbox"/> Other _____	<p>Income Assistance</p> <input type="checkbox"/> Emergency Financial Assistance <input type="checkbox"/> Financial Counseling <input type="checkbox"/> Food Stamps <input type="checkbox"/> Public Assistance <input type="checkbox"/> SSI <input type="checkbox"/> Other _____	<p>Medical/Health</p> <input type="checkbox"/> Assessment <input type="checkbox"/> Dental Services <input type="checkbox"/> Diagnostic/Advisory Clinics <input type="checkbox"/> Equipment/Devices <input type="checkbox"/> Health Insurance <input type="checkbox"/> Home Health Care <input type="checkbox"/> Hospitalization <input type="checkbox"/> Immunizations <input type="checkbox"/> Mental Health Services <input type="checkbox"/> Prenatal Care <input type="checkbox"/> Prescription Drugs <input type="checkbox"/> Primary Health Care <input type="checkbox"/> Screening <input type="checkbox"/> Substance Abuse Treatment <input type="checkbox"/> Surgical Procedure <input type="checkbox"/> Women, Infants, and Children (WIC) Program <input type="checkbox"/> Other _____	<p>Other</p> <input type="checkbox"/> Adult Education <input type="checkbox"/> Child Care Resource Center, Local <input type="checkbox"/> Family Support Center <input type="checkbox"/> Family Support Network, Local <input type="checkbox"/> Family Support Network, State <input type="checkbox"/> Home Visiting Program (Please specify) _____ <input type="checkbox"/> Housing <input type="checkbox"/> Judy Center <input type="checkbox"/> Legal Services <input type="checkbox"/> Parent Education <input type="checkbox"/> Project Independence <input type="checkbox"/> Recreation Program <input type="checkbox"/> Support Group <input type="checkbox"/> Other _____
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SERVICE LINKAGE PROVIDERS

Provider Name:	Provider Name:
Phone/E-mail:	Phone/E-mail:
Provider Name:	Provider Name:
Phone/E-mail:	Phone/E-mail:

STRATEGIES TO HELP SECURE SERVICE LINKAGES FOR THE FAMILY

PAYMENT SOURCES (Check all that apply.)	PERSON(S) INVOLVED TO SECURE SERVICE LINKAGES	
<input type="checkbox"/> Health Maintenance Organization (HMO) <input type="checkbox"/> Medical Assistance <input type="checkbox"/> No fee <input type="checkbox"/> Other Health Insurance <input type="checkbox"/> Parent: Full Payment <input type="checkbox"/> Parent: Sliding Fee <input type="checkbox"/> Other: _____	Name:	Name:
	Title:	Title:
	Phone:	Phone:
	E-mail:	E-mail:

Child Name:	ID Number:	IFSP Meeting Date:
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PART VI - AUTHORIZATION(S)

Authorization(s)

PARENT/GUARDIAN/SURROGATE CONSENT
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- I/We have had the opportunity to participate in the development of this Individualized Family Service Plan (IFSP) and have been provided reasonable notice of the IFSP meeting.
- I/We have been informed of my/our parental rights under this program through receipt of the *Parental Rights: Maryland Procedural Safeguards Notice* and a family handbook about Maryland's early intervention system.
- The early intervention services will be provided as described in the IFSP. I/We understand that the IFSP will be reviewed at least every six (6) months.
- I/We understand that my/our consent is voluntary and that I/we may revoke consent at any time.
- I/We understand the records will not be released without my/our signed and written consent except under the provisions of the Family Education Rights and Privacy Act (FERPA). This law allows the release of early intervention records to participating agencies in the early intervention system.
- I/We understand that the public agency will submit information through a statewide database. This database will be used by the Maryland State Department of Education (MSDE) and other State agencies, as appropriate, to enable funding of programs.
- I/We have been informed of the determination(s) of the IFSP team in my/our native language or other mode of communication.
- This plan reflects the outcomes that are important to my/our child and family.
- I/We understand the plan and parental rights and give permission to implement this IFSP.

Parent(s)/Guardian/Surrogate Signature

Date

MEDICAL ASSISTANCE

- I/We choose to accept Service Coordination for Children with Disabilities Case Management. I/we understand that the purpose of this service is to assist in gaining access to needed medical, social, educational, and other services. I/We understand that continuation of this service depends on meeting eligibility requirements for Service Coordination for Children with Disabilities, [COMAR 10.09.40].
- I/We understand that this service does not restrict or otherwise affect a participant's eligibility for other Medical Assistance benefits. I/We understand that I/we am free to choose a case manager/service coordinator for my/our child.
- I/We give permission to the provider agency to recover costs from Medicaid for service coordination, as well as health-related services, related to the implementation of my child's outcomes. I/We understand that if I/we refuse to allow the provider agency access to Medical Assistance funds, it does not relieve the public agency of its responsibility to ensure that all required services are provided to my/our child at no cost to my/our family.

Print Child's Name

Medical Assistance (MA) Number

Parent(s)/Guardian/Surrogate Signature

Date

Child Name:	ID Number:	IFSP Meeting Date:
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PART VII - MY CHILD'S TRANSITION INFORMATION
Section A - Transition At Age Three

Transition At Age 3

TRANSITION PLANNING MEETING DATE: _____

EXPLANATION FOR MEETING DELAY	
<p>If the Transition Planning Meeting is held after the child has reached 33 months of age, check the response below that provides an explanation. <i>(Check only one.)</i></p> <p><input type="checkbox"/> Attempts to contact family were unsuccessful.</p> <p><input type="checkbox"/> Child was referred at 31.5 months of age or later.</p> <p><input type="checkbox"/> Family requested to reschedule or delay the meeting.</p> <p><input type="checkbox"/> Other: _____</p>	<p>If the Transition Planning Meeting was not held at all prior to the child's third birthday, check the response below that provides an explanation. <i>(Check only one.)</i></p> <p><input type="checkbox"/> Attempts to contact family were unsuccessful.</p> <p><input type="checkbox"/> Child was referred at 34.5 months of age or later.</p> <p><input type="checkbox"/> Family declined to participate in the meeting.</p> <p><input type="checkbox"/> Other: _____</p>

CONSIDERATION OF ELIGIBILITY FOR PRESCHOOL SPECIAL EDUCATION AND RELATED SERVICES (PART B)	
<input type="checkbox"/> Parents wish to consider Part B eligibility.	<input type="checkbox"/> Parents DO NOT wish to consider Part B eligibility.

COMMUNITY SERVICES		
Is the family being referred to community services? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If YES, check the services that apply.		
<p>Developmental/Medical/Health:</p> <p><input type="checkbox"/> Developmental Therapies (other than Part C and Part B)</p> <p><input type="checkbox"/> Equipment/Devices</p> <p><input type="checkbox"/> Home Health Care</p> <p><input type="checkbox"/> Immunizations</p> <p><input type="checkbox"/> Mental Health Services</p> <p><input type="checkbox"/> Primary Health Care</p> <p><input type="checkbox"/> Women, Infants, and Children (WIC) Program</p>	<p>Child Care/Enrichment</p> <p><input type="checkbox"/> Camps</p> <p><input type="checkbox"/> Family Day Care</p> <p><input type="checkbox"/> Group Child Care</p> <p><input type="checkbox"/> Head Start</p> <p><input type="checkbox"/> Even Start</p> <p><input type="checkbox"/> Play Group</p> <p><input type="checkbox"/> Preschool Program: ___ Public ___ Private</p> <p><input type="checkbox"/> Recreation Program</p> <p><input type="checkbox"/> Judy Center</p> <p><input type="checkbox"/> Home Instruction for Parents of Preschool Youngsters (HIPPY)</p>	<p>Family Support</p> <p><input type="checkbox"/> Family Support Center</p> <p><input type="checkbox"/> Home Visiting Program (Please specify) _____</p> <p><input type="checkbox"/> Parent Education</p> <p><input type="checkbox"/> Support Group</p> <p><input type="checkbox"/> Other: _____</p> <p>Other Community Services:</p> <p>_____</p> <p>_____</p> <p>_____</p>

TRANSITION PLANNING MEETING NOTES/FUTURE STEPS		
Activities	Timelines	Person(s) Responsible

RESULTS OF THE INITIAL IEP ELIGIBILITY DETERMINATION MEETING (TO BE COMPLETED BY SPECIAL EDUCATION STAFF)
<p>SPECIAL EDUCATION STAFF: Complete this section and submit to Part C Data Entry immediately following the initial IEP eligibility determination meeting. <i>Check the statement that indicates results of the initial IEP eligibility determination meeting.</i></p> <p><input type="checkbox"/> The child is determined to be ELIGIBLE for ongoing services through an IFSP or preschool special education and related services through an IEP.</p> <p><input type="checkbox"/> The child is determined to be INELIGIBLE for ongoing services through an IFSP or preschool special education and related services through an IEP.</p>

PART VII - MY CHILD'S TRANSITION INFORMATION
Section B - Transition After Age Three

Transition After Age 3

CONSIDERATION OF SPECIAL EDUCATION AND RELATED SERVICES (PART B)

Prior to Kindergarten Age

- Parents wish to consider preschool special education and related services through an IEP.
- Parents **do not** wish to consider preschool special education and related services through an IEP.

At Kindergarten Age

- Parents wish to consider special education and related services through an IEP.
- Parents **do not** wish to consider special education and related services through an IEP.

COMMUNITY SERVICES

Is the family being referred to community services? Yes No **If YES, check the services that apply.**

<p>Developmental/Medical/Health:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Developmental Therapies (other than Part C and Part B) <input type="checkbox"/> Equipment/Devices <input type="checkbox"/> Home Health Care <input type="checkbox"/> Immunizations <input type="checkbox"/> Mental Health Services <input type="checkbox"/> Primary Health Care <input type="checkbox"/> Women, Infants, and Children (WIC) Program 	<p>Child Care/Enrichment</p> <ul style="list-style-type: none"> <input type="checkbox"/> Camps <input type="checkbox"/> Even Start <input type="checkbox"/> Family Day Care <input type="checkbox"/> Group Child Care <input type="checkbox"/> Head Start <input type="checkbox"/> Home Instruction for Parents of Preschool Youngsters (HIPPY) <input type="checkbox"/> Judy Center <input type="checkbox"/> Play Group <input type="checkbox"/> Preschool Program: <ul style="list-style-type: none"> <input type="checkbox"/> Public <input type="checkbox"/> Private <input type="checkbox"/> Recreation Program 	<p>Family Support</p> <ul style="list-style-type: none"> <input type="checkbox"/> Family Support Center <input type="checkbox"/> Home Visiting Program (Please specify) _____ <input type="checkbox"/> Parent Education <input type="checkbox"/> Support Group <input type="checkbox"/> Other: _____ <p>Other Community Services:</p> <p>_____</p> <p>_____</p> <p>_____</p>
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MEETING NOTES/FUTURE STEPS

Activities	Timelines	Person(s) Responsible

RESULTS OF IEP ELIGIBILITY DETERMINATION MEETING, IF APPLICABLE (TO BE COMPLETED BY SPECIAL EDUCATION STAFF)

SPECIAL EDUCATION STAFF: Complete this section and submit to Part C Data Entry **immediately following** the IEP eligibility determination meeting. *Check the statement that indicates results of the IEP eligibility determination meeting.*

- The child is determined to be **ELIGIBLE** for special education and related services through an IEP.
- The child is determined to be **INELIGIBLE** for special education and related services through an IEP.

Child Name:	ID Number:	IFSP Meeting Date:
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PART VIII - PARENT CONSENT (At or Before Age Three)
Family Choice: Consent to the Continuation or Request Termination of IFSP Services

Families Have A Choice

- I/We have received a copy of the Annual Notification, "A Family Guide to Next Steps When Your Child In Early Intervention Turns 3 – Families have a choice."
- I/We have been informed about the differences between the early intervention services provided through an Individualized Family Service Plan (IFSP) under the Individuals with Disabilities Education Act (IDEA) and the preschool special education services provided through an Individualized Education Program (IEP) under IDEA.
- I/We understand my/our child has a current IFSP and that my/our child has been found eligible for preschool special education as a child with a disability under IDEA.
- I/We have been informed of my/our right to choose between the IFSP Option to continue receiving early intervention services through an IFSP or to initiate special education preschool services through an IEP.
- I/We understand that if I/we choose for my/our child to receive services through an IEP and terminate IFSP services, my/our child and family will no longer be eligible through an IFSP.
- I/We understand that if I/we choose for my/our child to receive services through an IFSP, at any time I/we may terminate participation in early intervention services through an IFSP and choose to initiate special education preschool services through an IEP.
- I/We understand that the local lead agency is required to continue to provide IFSP services under the Extended IFSP Option until the date on which services through an IEP are initiated. However if, I/we choose the IEP option but refuse to consent to the special education and related services offered in the IEP developed by the IEP team, I/we understand IFSP services will be terminated.
- I/We understand that my/our consent to the continuation of IFSP services is voluntary and that I/we may revoke consent at any time.

FAMILY CHOICE

Check ONE box.

- I/We consent to the **continuation** of early intervention services for my/our child and family through an IFSP after my/our child's third birthday.
- I/We request **termination** of early intervention services for my/our child and family through an IFSP at age 3.

Parent(s)/Guardian/Surrogate Signature

Date

Service Coordinator

Date

Other Participant

Agency/Title

Date

Other Participant

Agency/Title

Date

Child Name: _____	ID Number: _____	IFSP Meeting Date: _____
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**Individualized Family Service Plan (IFSP)
ADD/CHANGE FORM**

IFSP Review

CHANGES TO CHILD AND FAMILY INFORMATION	REVIEW OF THE IFSP
<i>(Changes to demographic information do NOT require a parent signature.)</i>	Review Type: Select one .
Child Information:	Meeting Date: _____
Child's Name: _____	<input type="checkbox"/> Six Month
Address: _____	<input type="checkbox"/> Annual
_____	<input type="checkbox"/> Provider Request
Phone: _____	<input type="checkbox"/> Parent Request
Birthdate: _____	<input type="checkbox"/> Parent/Provider Request
Medical Assistance #: _____	Review Status: Select one .
Family Information:	<input type="checkbox"/> Continue IFSP
Name: _____	<input type="checkbox"/> Modify IFSP
Address: _____	<input type="checkbox"/> Service Addition
_____	<input type="checkbox"/> Service Modification
Phone: _____	<input type="checkbox"/> Service Ending
E-mail: _____	<input type="checkbox"/> Add/Modify Outcomes
Relationship to Child: _____	<input type="checkbox"/> End IFSP <i>(If selected, complete the "Reason for Inactive Status" section below.)</i>
Service Coordinator Information:	Reasons for Inactive Status: Select one .
Name: _____	Inactive Date: _____
Agency: _____	<input type="checkbox"/> Attempts to contact were unsuccessful <i>(Birth to Kindergarten Age)</i>
Phone: _____	<input type="checkbox"/> Completion of IFSP prior to reaching age 3 <i>(Birth to 3)</i>
E-mail: _____	<input type="checkbox"/> Deceased <i>(Birth to Kindergarten Age)</i>
	<input type="checkbox"/> Determined ineligible - Note: Child was never eligible <i>(Birth to 3)</i>
	<input type="checkbox"/> Moved out of state <i>(Birth to Kindergarten Age)</i>
	<input type="checkbox"/> Moved to another jurisdiction <i>(Birth to Kindergarten Age)</i>
	<input type="checkbox"/> Parent withdrawal <i>(Birth to Kindergarten Age)</i>
	<input type="checkbox"/> Transition at age 3 - Not continuing on an IFSP <i>(Birth to 3)</i>
	<input type="checkbox"/> Completion of IFSP prior to reaching Kindergarten Age <i>(Age 3 to Kindergarten Age)</i>
	<input type="checkbox"/> Transition after age 3 <i>(Age 3 to Kindergarten Age)</i>

I/We have been provided with reasonable notice of the review of this IFSP. I/We have had the opportunity to participate in the review of this IFSP. I/We have been informed of my/our parental rights through the *Parental Rights: Maryland Procedural Safeguards Notice* and give permission to the early intervention program to implement any IFSP revisions based on this review.

Parent(s)/Guardian/Surrogate Signature _____
Date

Service Coordinator _____
Date

Other Participant _____
Agency/Title _____
Date

Other Participant _____
Agency/Title _____
Date