

## INDIVIDUALIZED FAMILY SUPPORT PLAN

CHILD'S NAME: \_\_\_\_\_ D.O.B. \_\_\_\_\_

DATE IFSP COMPLETED: \_\_\_\_\_

DATE IFSP REVIEWED: 6(mo) \_\_\_\_\_

Care Coordinator: \_\_\_\_\_

Program: Early Intervention Section

### I. INFORMATION ABOUT OUR CHILD AND FAMILY

#### A. CHILD'S PRESENT LEVELS OF DEVELOPMENT

Area	Date of Evaluation or When Information Gathered and Chronological and/or Adjusted Age	Statement of present level of development (Developmental months or narrative)	Criteria Used
Cognitive			
Communication (Speech & Language)			
Physical			
Fine Motor			
Gross Motor			
Vision			
Hearing			
Health Status			
Social Emotional			

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Adaptive (Self Help)			

SAMPLE ONLY

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**I. INFORMATION ABOUT OUR CHILD AND FAMILY (Cont'd)**

**B. OUR CHILD'S STRENGTHS/QUALITIES:**

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**C. OUR FAMILY'S CONCERNS AND PRIORITIES:**

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(Family declined to complete this section  YES )

**D. OUR FAMILY'S STRENGTHS AND RESOURCES:**

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(Family declined to complete this section  YES )

SAMPLE ONLY

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DATE IFSP COMPLETED: \_\_\_\_\_

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Outcome # \_\_\_\_: (what do we want for your child/family?) \_\_\_\_\_

What is happening now with our child/family? \_\_\_\_\_

<b>OBJECTIVES:</b> What changes I/We would want for our child and/or family. <i>(include measurable methods, timeframe, and how progress will be evaluated)</i>	<b>STRATEGIES:</b> Activities for working on the objective during your child and family's daily activities/routines. <i>(include when, where, and how long activity will take place.)</i>	<b>REVIEW</b> of progress towards reaching our child/family outcomes. <i>Record any progress and changes; also determine if objectives have been MET, PROGRESSING, or MODIFIED.</i>
		

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### II. SUMMARY OF EARLY INTERVENTION SERVICES:

Mandated Early Intervention Services Options		Method	Location	Funding Source	Review of Service
Assistive Technology Audiological Services Family Counseling Health Services Medical Diagnostic Serv. Nursing Services Nutrition Services Occupational Therapy Care Coordination	Physical Therapy Psychological Services Social Work Services Speech/Language Therapy Transportation Special Instruction Vision Services	Individual (I) Group (G) Consultation (C) Transdisciplinary (T)	<u>Natural:</u> 1. Home 2. Family Child Care 3. Child Care Center or Preschool 4. Other Setting <u>Non-Natural:</u> 5. Early Intervention Program 6. Hospital Inpatient 7. Office Setting 8. Other Setting	A. Federal Funds B. State Funds C. Local Funds D. Private Insurance E. Medicaid (Fee-For-Service) F. Quest G. Title V/CSHNB H. Title V/MCH I. Other	Modify No Change End of Service Change of Provider

Services	Related to Outcome #'s	Frequency/ Intensity	Method	Duration		Location	Provider Information	Funding Source	Review Service
				Start Date	End Date				
Care Coordination		1x/month or as needed	I				Early Intervention Section	A, B, D	
Speech and Language Therapy									

Notes:

\* Provider may change due to availability and/or appropriateness of services.

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**III. OTHER SERVICES**

SERVICES	START DATE	END DATE	LOCATION	PROVIDER INFORMATION
Pediatric Services		ongoing		

**IV. NATURAL ENVIRONMENTS: If not a natural environment, state why other environment was selected.**

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### V. TRANSITION PLAN

SPECIFIC PLANS AND ACTIVITIES	START DATE	COMMENTS/NEXT STEPS (What, where, how)
Discuss eligibility and age guidelines for Early Intervention so we can understand when our child may no longer be eligible for Early Intervention services.		
Discussed what "transition" from Early Intervention means and what we can do to plan for this transition.		
Transition booklet (STEPS To Transition) and Transition list shared and discussed with my family.		
Identify concerns and priorities for my/our child's future upon leaving the Early Intervention Program.		
Help us explore community program and other options for our child when it is time to leave Early Intervention system		
Plan a meeting with our family, care coordinator, and someone from the new program(s) to explore transition options from the Early Intervention Program. Have Transition Conference meeting at least 90 days prior to transitioning from Early Intervention.		
With our written permission, provide copies of Early Intervention generated information (reports, evaluations, IFSP, etc.) to share with the future service provider.		
If interested/appropriate, help us explore preschool special education services for our child. DOE 101 SST Meeting Eligibility Determination Meeting IEP Meeting		
Help our child prepare for changes in services so that we can move smoothly from one program to another (e.g. meet the teacher, visit classroom, training/consultation, etc.).		
Help our family prepare for changes in services so that we can move smoothly from one program to another (e.g. meet the teacher, visit classroom, training/consultation, etc.).		
Provide follow up contact with the family three months after transition has been completed.		
Other:		

Preferred / Receiving Program: \_\_\_\_\_

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**VI. Family members and service provider(s) who provided input into the development of the IFSP**

*(I/we agree to be named as co-care coordinator(s). The naming of parents as co-care coordinators will not diminish the responsibility and accountability of the agency or program to provide care coordination services.)* YES \_\_\_\_ NO

TEAM MEMBERS	POSITION/ROLE	✓ IF PRESENT	IF NOT PRESENT HOW DID MEMBER PARTICIPATE (e.g. phone, report, etc)	AGENCY/ADDRESS	PHONE #	APPROVED TO SEND COPY TO:	DATE SENT
	mother	<input type="checkbox"/>				<input type="checkbox"/>	
	father	<input type="checkbox"/>				<input type="checkbox"/>	
	pediatrician	<input type="checkbox"/>				<input type="checkbox"/>	
Sheri Yoshioka, MSW,LSW	Care Coordinator	<input checked="" type="checkbox"/>		Early Intervention Section 1600 Kapiolani Blvd. #1401 Honolulu, HI 96814	973-9679	<input type="checkbox"/>	
						<input type="checkbox"/>	
						<input type="checkbox"/>	
						<input type="checkbox"/>	

This IFSP was completed with me/us. I/we understand what it means and consent to implementing the services described in this document. I/we have received a copy of the "Dear Family" parent rights brochure for early intervention services.

Parent/Guardian Signature: \_\_\_\_\_

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

Parent/Guardian Signature: \_\_\_\_\_

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

