North Hawai'i Child Development Program
75-5769 Kuakini Hwy. #203
Kailua-Kona, HI 96740

To:	From:
Date:	Re: Your Patient: DOB:

Your patient has been assessed and is eligible for early intervention services from our program. I have been designated as the child and family's care coordinator.

The next step is to hold a meeting to create the Individualized Family Support Plan (IFSP). The IFSP is:

- A document which lists the child and family's strengths and areas in which they need support and/or therapy.
- Created by a team including the family, myself, any extended family members, friends, and/or advocates who the family chooses to invite, and other professionals who work with the child and/or family, ideally including ***you***, the PCP.
- A plan which uses short- and long-term objectives to help gauge progress.

We have scheduled the IFSP meeting, and we would appreciate any input you have. If you are able to attend the meeting, please call to confirm date and time. If you are unable to attend, you may use the attached 2 pages to provide input. Please fax it to me (808-885-8054) at least 2 days before the meeting, and I will share it at the meeting. Or, you can call me at 808-885-0086 x18 to give me your input.

Date: ______________________________

Time: ______________________________

Location: ______________________________

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Sincerely,

____
Care Coordinator

Attachment

Confidential Fax

To: North Hawaiʻi Child Development Program **Fax:** 808-885-8054

Attn:

From: **Date**:

Re Patient: **Pages:**
(DOB: ____________________)

COMMENTS:____

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Should you have difficulties or questions receiving this transmission, please call sender at 808-885-0086 x18.

Patient Name:____**(DOB** ____________**)**

Input for Individual Family Service Plan from ___________________________________

(Physician)

____

(Date)

☐ I do not have any concerns at this time.

☐ Medical/other concerns listed below: