



Individualized Family Support Plan (IFSP)

Your Family's Information								
Child's Information								
Child's Name:								
La	st	First	MI	AKA				
DOB:	Child ID #:		Gender:					
Caregiver(s)								
Caregiver Type:								
Caregiver Name(s):			<u></u>					
Address.			<u></u>					
City:	Zip Code:	Coun	ty:					
Cell Phone:	Home Phone:	Work Phone:		Ext:				
Best time to call:	En	nail:						
Caregiver Type:								
Caregiver Name(s):								
Address:								
City:	Zip Code:	Coun	ty:					
Cell Phone:	Home Phone:	Work Phone:		Ext:				
Best time to call:	En	nail:						
Language								
Child's Primary Language/Mode	of Communication:							
Primary Language Used in Hom	e/Mode of Communication:			_				
Is an Interpreter needed for the	family?							
IFSP Information								
Referral Date:	Periodic Due Date:							
Initial IFSP Due Date:	Actual Periodic Date:							
Actual Initial Date:	First Annual Due Date:		Second Annual Due D	ate:				
Actual Annual Date:	Current IFSP Date:							
Date Child Turning 3:	Interim IFSP (If Applicable	e):						
Transition Due Between:	&	<u></u>						
IFSP Type:	│ ○ Periodic ○ Annual							
Contact Information								
Agency:								
Service Coordinator:								
Phone:	Ext: Fax:	Email:						
Address:	City	/:	Zip:					
Family Resource Specialist:								
Phone:	Ext: Fax:	Email:						
Address:	City	<i>r</i> :	Zip:					

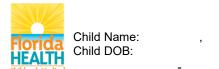


Young children learn best through routines and activities that they are interested in and participate in often. It is helpful for us to know where and how your child regularly spends time so that we can develop this plan. As you and your Service Coordinator talk about your daily routines, she/he will summarize that information below.

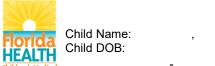
What brought you to Early Steps? Family: Who lives in your household? Add Family Member Name: Relationship: Self (Child) Routine/Participants: Your child is able to complete the following routines: What do you and your child enjoy about Caregivers Ability to **Routines** Location **Times** this activity? What makes this Involved **Accomplish** routine/activity challenging or difficult? **Morning Activities** Getting up in the morning Dressing Toileting Nap Time Inside Play Other: Other: **Daytime Activities** Traveling in the car Childcare Going from one activity to another Outside play Going out to eat Community Activities Religious services Attending medical appointments/ Doctor visits **Grocery Shopping** Other: Other: **Evening Activities** Meal Time Bath Time Family Games Going to Bed Other: Other: Successes: What successes would you like to share about your child's development? What are your favorite family experiences with your child? Concerns: What are your most important concerns about your child's development? What difficulties does your family/child experience during your daily routine? Priorities: What are your priorities? What would you like Early Steps to focus on? Additional Information: Is there anything else you would like to share?



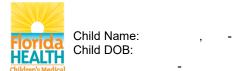
Services								
			Health Status	s & Insura	ance			
Date information gathered:			Chronological age:			months		
Primary Pediatrician			Other Physician(s)			Physician Type	Phone	
i minary i ediamician			Otherring	siciali(s)		i ilysiciali i ype	1 Hone	
Office Name								
Onioc Name								
Address								
71441000								
City	State	Zip						
···,	FL	p						
Phone	Fax							
Primary Insurance	N/A	ember ID	Group/MED	Type	Policy Ho	older	DOB	
Filliary insurance	IVIC	ellinei in	Group/MED	туре	Folicy Fit	Jidei	ров	
Secondary Insurance								
Occordary insurance								
Bill Private Insurance:								
	_	141						
Tell us about your ch			Data	- f - l-: - /-	4			
Was your child born fu					ast well ch			
How many weeks? _		_	0 0	oz. or		g Are immunization		
Is your child currently on				Does you			ns and/or diagnosis?	
If so, what types and wh	y? Pleas	e List:			If yes,	please describe:		
Has your child been hos	nitalized	2		Describe	any family	medical history that m	nay he important for the	
Please describe when &		•	_	Describe any family medical history that may be important for the team to know:				
T TOGOG GOOGLES WHOLL G	•••••			todin to know.				
Does your child have alle	ergies?						al/therapy evaluations	
Describe:				your child	d has receiv	red:		
Your child's nutritional habits/preferences. Describe: Your child's sleep patterns (bedtime, naps, hours of sleep) Describe.							ours of sleen) Describe:	
Tour Gring's fluctuotial flabits/preferences. Describe.						ours or sleep) bescribe.		
Hearing				Vision				
When was your child's mo	st recent	hearing screening	?	When was your child's most recent vision screening?				
What were the results?				What wer	e the results	?		
Do you have concerns a	hout you	r child's hearing?		Do you h	ave concer	ns about your child's v	vision?	
Describe:	bout you	i child 3 ficaling:		Describe		ns about your office 5 v	//3/011:	
2000201				200020	•			
Developmental Screen	ing: Wa	s a development	al screening co	nducted to	oday?	-		
Please list the tools/meth	node use	·q.			- ,			
1 loado not alo todio/mot	1000 000	d.						
As a result of the screen	ing, ther	e are possible del	ays in the follow	ing areas o	f developm	ent:		
Adaptive S	Social-En	notional 🔲 Co	ommunication	Moto	r 🔲 (Cognitive 🔲 No	ne	
Person completing scree	ening (Pr	int Name):						
	<u> </u>					_		
Next Steps:								



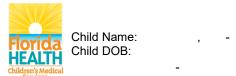
Services									
Your Child's Service Coordination/Targeted Case Management Plan									
Your Service Coordinator's name is . He/she can be reached by phone at . and by email at . The family Resource Specialist, . , is also available to provide parent support. He/she can be reached at . or by email at .									
Targeted Case Management Review Date(s):									
Services and Supports your Service Coordinator/Targeted Case Manager can assist with:									
Developmental/Health		Currently Receiving	Wo	uld Like Help Receiving	NA				
Developmental Monitoring									
Developmental Evaluation									
Developmental Services									
Counseling Assistance									
Dental Services									
Home Health Care									
Immunizations									
Medical Insurance									
Mental Health Care									
Substance Abuse									
Nutrition Classes									
Prenatal Care									
Primary Health Care									
Child Care/Enrichment									
Before/After Childcare									
Camps									
Child Care/Enrichment									
Early Head Start/Head Start									
Parenting Classes									
Income Assistance									
Emergency Financial Support									
Food Stamps/SNAP									
Low Income Housing									
Public Assistance/TANF									
SSI/SSDI									
Transportation									
WIC									
Other									
Accessibility									
Adult Education									
Equipment									
Recreation Programs									
Safety									
Support Groups									
Other:									
Other:									
Additional services and/or suppo	orts your child or	family are receiving th	at are hel	pful to share with t	he Individualized				
Family Support Plan team:	·								
Your Child's Service Coordinato	r/Targeted Case	Management Goals:							
					Add Referral				
Person Responsible for Providing	Date of	Agency/Individual to	Whom	Referrals/Activities to be Completed by					
Assistance or Support	Referral/Activity			Service Coordinator					
		1							



nildren's Medi Services	ica1	Your Chi	ld's Assessment/Eligil	hility Determinati	ion Part I		
		l successful part	icipants at home and in the	e community, they r	need to develop skills in		
areas of		use this informat	tion about your child's abili	ties and your conce	rns and priorities to un	derstand	your child's
Date o	Mo	onths					
Instrun	nents/Sources Used:						
Fu	nctional Areas	What are some t What skills does	Your Child Does Well hings your child likes to do? s your child demonstrate or ing to demonstrate?	What are skills that or skills that are dit what activities or sk	Child Finds Difficult your child does not do fficult for your child? In ill areas does your child and/or practice?	deve levels b evalu asse	ur child's lopmental pased on the uation and essment:
DEVELOPLING POSITIVE SOCIAL- EMOTIONAL SKILLS	This includes your child's ability to engage others including developing relationships, self-soothing strategies for becoming and remaining calm, getting along with others, and expressing feelings.	Periodic Revie	w			Social/	Emotional: Score Indicates an area of delay as defined by Early Steps
ACQUIRING AND USING KNOWLEDGE AND SKILLS	This refers to your child's ability in areas such as thinking, reasoning, remembering, problem solving, number concepts, and counting. It					Comm	Score Indicates an area of delay
ACG	also includes skills related to language and literacy.	Periodic Review	1				as defined by Early Steps
	This includes your					Gross I	ine Motor:
USING APPROPRIATE CTIONS TO MEET NEEDS	This includes your child's ability to take care of basic needs such as getting from one						Score Indicates an area of delay as defined by Early Steps
PR(place to another,					Self He	-
USING AP ACTIONS TO	dressing, feeding, toileting, and using tools (forks, toothbrushes, crayons).	Periodic Revie	W				Score Indicates an area of delay as defined by Early Steps
Obser	vations/Comments/I	nformed Clinica	al Opinion:			l	

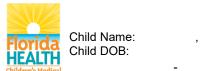


Your Child's Assessment/Eligibility Determination Part II							
Vision and Hearing Status:							
Eligibility:							
<u> </u>							
Next Steps:							
Below are the participants of	the multidisciplinary team, in add	ition to the family:					
Evaluator/Assessor:	Discipline:	Signature:	Date:				
Evaluator/Assessor:	Discipline:	Signature:	Date:				
	Biccipinite:		<u> </u>				
Evaluator/Assessor:	Discipline:	Signature:	Date:				
Evaluator/Assessor:	Discipline:	Signature:	Date:				
	Biccipinie.		Bate				
Service Coordinator:		Signature:	Date:				
Other:	Role:	Signature:	Date:				
Other.	Troie.	Olgitature.	Date.				
Other:	Role:	Signature:	Date:				
Othor	Polo	Signatura	Data				
Other:	Role:	Signature:	Date:				



Outcomes								
Outcomes are the benefits for your child and family as a result of Early Steps services and supports based on your priorities. The team will develop strategies and timelines to determine progress towards achieving the outcomes. Outcome #								
Given what you've shared about your family's daily life, what would you like to see happen in your daily routines as a result of Early Steps services?								
This outcome is related to the following functional area(s):								
Please describe how progress will look in three months:								
Please describe how progress will look in six months:								
Strategies: Below are the steps to accomplish this outcome and the role of each team member:								
Action Steps Team Members								
IFSP Review: Review Date(s):								
─────────────────────────────────────								
Progress: Please describe progress toward meeting this outcome.								
Please describe the next steps:								

Add Outcome



Services											
Services Needed to Achieve Early Intervention Outcomes											
The below services						eeting the d	levelopmer	ital nee	eds of your	child	. You have
the right to accept of	the right to accept or decline some or all the recommended services.										
	Add Early Steps Service										
Service Description	Outcome #	Frequency	Intensity (Minutes)					ces st	Payer		
Non-Natural Envir	onment J	ustification									
Services must be p This means setting environment). As a	rovided in s, including	day-to-day ro g home and c	ommunity s	ettings, that a	re natural c	or typical for	your child's	s age p	eers (natu	ıral	-
Diagnosis Codes:											
ICD-10 Codes	10	CD-10 Descri _l	otion								
Medical Necessity	if Applic	able: If your o	hild is a Madi	looid rooiniont	the continue	raimburaad b	, Madiaaid n	auat ha	madically		am. The
following is an explan									medically no	ecessa	ary. The
Tollowing to all explain	ation of the	medical neces	or your or	ind 5 SCI VIOCS V	vicinii ali ilitoi	vention and p	orevertion in	odoi.			
Plan Approval											
☐ I participated for	ully in the	development o	of this plan.								
☐ A copy of my p	•	•	•	Family Right	s) has beer	explained a	and provide	ed to m	ie.		
☐ I give consent										vritter	١.
☐ I do not provide							() 10				
_ 1 do 110t provid	0 001100111		9 00. 1.000	rocommonac	a by my m	_					
Parent/Guardian	Signature	:					Date:				
Parent/Guardian	Signaturo						Date:				
Consent for Servi										F.S.	
I give consent for m	nedical car	e and treatme	ent per Sect	ion 743.0645	, ⊢lorida Sta	atutes, and a	as modified	in this	IFSP		
DCF Caseworker/I	Designee S	Signature:						Da	ate:		
	-	_							-		

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		Transi	tion					
The Transition plan outlines the			nild and f	amily as yοι	ı leave Early Steps.			
Preparing for Your Transition								
The following are options your fa Local school d Head Start Agency for Per Early care and Other:	istrict (Pre-K	isabilities	urns thre	e:				
The Understanding Notification Brochure was provided. Notification was provided to the local school district. Notification was provided to the Department of Education. Additional information regarding Notification, if applicable: Date: Date:								
Your Transition Conference								
Transition Conference Date:		<u></u>						
What are your most important qu	uestions or c	oncerns regarding your o	child's tra	nsition from	Early Steps?			
The following activities will occur	to address	your questions and cond	erns:					
The below agency/programs pro	vided inform	ation regarding their ser	vices that	t included th	e evaluation/eligibility proc	ess:		
The following activities will su	pport your	child's transition into a	new set	ting/enviro	nment:	Add A	ctivities	
Family will:	Timeline	Agency/Program will:		Timeline	Service Coordinator will:		Timeline	
•		•						
We attended the transition cor	nference and	 d participated in the de	velopme	ent of this to	ransition plan.			
Parent/Guardian		Date	Parent	/Guardian		Date		
Service Coordinator		Date	Local	School Distri	ict Representative	Date		
Program/Agency Representative Date		Date	Program/Agency Representative Date					
Other		Date	Other			Date		