

NORTH CAROLINA INFANT-TODDLER PROGRAM INDIVIDUALIZED FAMILY SERVICE PLAN

Important Dates and Events

#ECHO



I. Individualized Family Service Plan (IFSP)

Child's Name:	
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Age at Referral:	Date of Referral:
IFSP Meeting Date:	IFSP Start Date:
Interim IFSP Date: <input type="checkbox"/> N/A	
Parent's Name:	Parent's Name:
Address:	Address:
City/State/Zip:	City/State/Zip:
Phone Number(s): () - Work <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> () - Work <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> () - Work <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/>	Phone Number(s): () - Work <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> () - Work <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> () - Work <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/>
Email Address(es): @ .com	Email Address(es): @ .com
Language of parent:	Language of child:
Resident School District: Charlotte Mecklenburg	
County: Mecklenburg	

I. IFSP Team

Name	Relationship/Role	Phone Number	Address	Start Date	End Date
	Choose an item.	() -			
	Choose an item.	() -	Mecklenburg County Children's Developmental Services Dr. Carlton G. Watkins Center 3500 Ellington Street, Charlotte, NC 28211		
	Choose an item.	() -	Agency		
	Choose an item.	() -	Agency		
	Choose an item.	() -	Agency		

II. Family's Concerns, Priorities, and Resources

Your family's concerns and priorities related to your child's functioning and learning are the focus of your family's Individualized Family Service Plan (IFSP) including the outcomes or goals. The information you choose to provide about your family's strengths, resources and supports is very important and helpful as we all work together to achieve your desired outcomes for your child and family.

Date Family Assessment Completed:	Participants/Team Members:	Name of Family-directed Assessment Tool: Tactics/Ecomap
Family's Areas of Concern: (Describe challenges or difficulties your child and/or family encounter during everyday activities and routines.)		
Priorities of the Family: (What could we start with right now that would make a difference for your family?)		
Strengths and resources that assist in meeting the needs of your child and family: (Include people that provide a support system for your family, such as relatives, family friends, co-workers as well as any agencies or services. Also include activities and outings that your child and family enjoy doing, such as playgroups, library story time, going to the park, having picnics, etc.)		
Additional Information: Is there anything else you would like for us to know that may be helpful as we plan supports and services to address what is most important to your child and family?		

III. Summary of Child's Present Abilities and Strengths

Child's Present Skills and Abilities:

This section of the IFSP provides a picture of your child's strengths and needs, the people, places and things that interest and motivates your child, and his/her likes and dislikes. The CDSA used several methods to look at your child's development: standardized testing, record review, clinical observation, and parent report. The information that we gathered informs us about the skills and behaviors that your child has developed so far and how your child combines and uses these skills and behaviors to participate in daily activities. The skills and behaviors are divided into five domains (areas of development).

Date(s) of Evaluation/Assessment:		Who Participated:	
Child's Age:		Adjusted Age:	
Evaluation/Assessment Tools/Other Methods Used: Developmental Assessment of Young Children, 2 nd Edition (DayC-2), clinical observation, parent report			
Developmental Domain	Skills & Abilities		
	Things (child's name) Does Well		Challenges or Next Steps for (child's name)
Social/Emotional (Relating to other people, showing feelings, coping in situations throughout the day) Evaluator Name / Discipline: Developmental Age: Standard Score (+/-6):	•		•
Adaptive (Ability to help self in daily activities, including feeding, dressing, toileting, sleeping, and getting needs met) Evaluator Name / Discipline: Developmental Age: Standard Score (+/-6):	•		•
Cognitive (Thinking and learning, how the child solves problems) Evaluator Name / Discipline: Developmental Age: Standard Score (+/-6):	•		•

III. Summary of Child's Present Abilities and Strengths

<p>Communication (Understanding words and gestures (receptive language), and using sounds, words and gestures (expressive language))</p> <p>Evaluator Name / Discipline:</p> <p><u>Receptive:</u> Developmental Age: Standard Score (+/-10):</p> <p><u>Expressive:</u> Developmental Age: Standard Score (+/-8):</p>	<p><u>Receptive</u></p> <p>•</p> <p><u>Expressive</u></p> <p>•</p>	<p><u>Receptive</u></p> <p>•</p> <p><u>Expressive</u></p> <p>•</p>
<p>Physical Development (Using hands and using eyes and hands together with control and coordination (fine motor), the child's strength, coordination and balance of muscles for movement (gross motor))</p> <p>Evaluator Name / Discipline:</p> <p><u>Gross Motor</u> Developmental Age: Standard Score (+/-6):</p> <p><u>Fine Motor:</u> Developmental Age: Standard Score (+/-8):</p>	<p><u>Gross Motor</u></p> <p>•</p> <p><u>Fine Motor</u></p> <p>•</p>	<p><u>Gross Motor</u></p> <p>•</p> <p><u>Fine Motor</u></p> <p>•</p>

III. Summary of Child's Present Abilities and Strengths

Child's Health Information:

Summary of child's current health status based on review of pertinent records and/or parent report. *(This may include child's birth history, medical conditions or diagnoses, illnesses, hospitalizations, medications, vision and hearing status, or other information):*

What else should the team know about your child's health so we can better plan and provide supports and services to your child and family?

III. Summary of Child's Present Abilities and Strengths

Assessment

Include a summary of functional assessments and observations of the child in his/her day-to-day environment. Information noted in this section may include summary from the initial child assessment or on-going child assessments. This section of the IFSP provides information that will be helpful in determining supports and services that are most appropriate to meet the specific child's needs. List individuals involved in the assessment, procedures, results and child's unique strengths and needs. Address all developmental domains if this is an initial child assessment.

Functional child assessments:

- Are based upon on-going observation of child engaged in everyday activities with people they know, in natural settings
- Engage families and caregivers as active participants
- Are individualized to address each child's unique way of learning
- Reflect that development and learning are rooted in culture and supported by the family
- Integrate information across activity settings

Date	Description
	<p>An initial child assessment was completed by _____ (evaluator name /discipline) and _____, Service Coordinator, which included observation and parent report. _____ (Parent(s) or family member name(s), participated in the assessment, which occurred in the family's home.</p> <p><u>Dressing / Bathing / Diapering:</u></p> <p><u>Playtime / Outings:</u></p> <p><u>Mealtimes / Snacks:</u></p>

III. Summary of Child's Present Abilities and Strengths

Date	Description
Continued	<p><u>Sleep/Naps:</u></p> <p><u>Childcare:</u></p>

III. Summary of Child's Present Abilities and Strengths

Initial Evaluation and/or Child Assessment Results:

Evaluators Signature

Date

Evaluators Signature

Date

Evaluators Signature

Date

IV. IFSP Outcomes

Outcomes must be measurable and reflect changes the family would like to see happen for themselves and their child.

<p>Outcome # _____ What would you and your family like to see happen for your child/family in the next six months? (The outcome must be functional and in the context of everyday routines and activities.)</p>	<p>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.)</p>
<p>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/family to achieve your goals within your daily routines and activities. List who will do what.)</p>	<p>How will we know we've made progress or if revisions are needed to the outcomes, strategies or services? (What observable action or behavior will we see that will show us that progress is being made? Are there other procedures being used to measure progress? What realistic timelines will be used to determine progress?)</p> <p>Start Date: _____</p> <p>Target Date: _____</p> <p>How did we do? (Review of progress statement/Criteria for success)</p> <p>Date: _____ Achieved. We did it!</p> <p>Date: _____ Continue. We are part way there. Let's keep going.</p> <p>The situation has changed:</p> <p>Date: _____ Discontinue. It no longer applies.</p> <p>Date: _____ Revise. Let's try something different.</p> <p>Date: _____ Explanations/Comments</p>

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V. IFSP Service Delivery Plan

Primary Place of Early Intervention Services:								
Early Intervention Service	Provider	Projected Start Date	Actual Start Date	Location/Most Natural Environment	Frequency/Length/ Intensity/ Method	Payment Arrangement & Cost to Family	Anticipated Duration	Date Ended
Service Coordination/TCM	Mecklenburg County Children's Developmental Services			Choose an item.	1 x per month 60 minutes Individual	Choose an item.		
Choose an item.	Agency			Choose an item.		Choose an item.		
Choose an item.	Agency			Choose an item.		Choose an item.		
Choose an item.	Agency			Choose an item.		Choose an item.		
Other Services:	Provider:	Start Date:	End Date:	If needed, how EI will help family access other services:				

VII. Transition Planning

Transition Plans and Activities	Specific Action	Person Responsible	Date Started	Date Completed
<p>1. Discuss what “transition” from early intervention means.</p>	<ul style="list-style-type: none"> Family was informed that their child will “transition” out of the Infant-Toddler program at age three. Transition is a process, not an isolated event; therefore, the IFSP team is beginning now to plan for the changes in supports and services that will occur when the child turns three years old. The child will no longer be eligible for Part C early intervention services at that time nor will they have the benefit of the I-T sliding fee scale or the I-T contracted rate for services. <i>Early Childhood Transitions in North Carolina</i> booklet was provided and reviewed with the family. A formal Transition Planning Conference (TPC) will be scheduled with the family. 	Service Coordinator	<i>(date of initial discussion to be held between 2y3m and 2y6m)</i>	<i>(date of initial discussion to be held between 2y3m and 2y6m)</i>
<p>2. Discuss <u>possible</u> 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 for Part C.</p>		Service Coordinator	<i>(date SC begins this conversation)</i>	<i>(TPC date)</i>
<p>3. Child Find: The LEA where the child resides has been notified.</p>	<p>In North Carolina, all children enrolled in Early Intervention are potentially eligible for Preschool Services (Part B). The CDSA is required to report the following information to the local school system when a child turns 2 years 3 months old or as soon as the child is enrolled in Early Intervention: child’s name, date of birth, telephone number, and parents’ names. No other information is disclosed without written parental permission and it is still the parent who consents to refer for eligibility determination.</p>	CDSA staff – Office Assistant	Sent when child turns 2 years, 3 months old	Sent when child turns 2 years, 3 months old
<p>4. Send specified information to Part B if parental consent is provided. Yes <input type="checkbox"/> No <input type="checkbox"/></p>		Service Coordinator	<i>(date sent)</i>	<i>(date sent)</i>
<p>5. Provide an opportunity for parents to meet and receive information from the local education agency and/or other community program representatives as appropriate and meet to develop a transition plan with steps, activities and transition services.</p>			<i>(TPC date)</i>	<i>(TPC date)</i>
<p>6. 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.</p>			<i>(TPC date)</i>	<i>(Child’s 3rd birthday)</i>

VIII. IFSP Agreement

Prior Written Notice

Reason for Prior Written Notice: Prior written notice must be provided to parents ten (10) days before the North Carolina Infant-Toddler Program proposes, or refuses, to initiate or change the provision of early intervention services for your child and family. You may agree to have the proposed action(s) occur sooner and not wait the ten (10) days.

Action Proposed: To initiate the services listed on the IFSP for which consent is provided, according to the Service Delivery Plan.

Reasons for Taking the Action: After discussing all assessment information, including family observations, concerns, priorities and resources, the IFSP team, including the family, agreed on the early intervention services and other supports to be provided to achieve the established outcomes.

Notice of Rights and Procedural Safeguards

_____ (*initial*) I have received a copy of **NC Infant-Toddler Program Notice Child and Family Rights** along with this prior written notice. This information includes all the procedural safeguards that are available, including a description of complaint procedures and the timelines for those procedures. These rights have been explained to me and I understand them.

Parental Consent for Provision of Early Intervention Services

I participated in the development of this IFSP. I understand my consent is voluntary and may be revoked in writing at any time. I understand that I may decline a service or services without jeopardizing any other early intervention service(s). I understand that my child will not receive the NC ITP services identified on the IFSP unless I give my written consent.

Check one of the following:

- I consent for the NC Infant-Toddler Program and service providers to provide the NC ITP services and activities listed on the IFSP.
- I decline for my child or family to receive: (specify) _____
— AND — _____

I consent for the NC ITP and service providers to provide all other NC ITP services and to carry out all other activities listed on this IFSP, EXCLUDING the service or services I have specified here. _____

Consent to Bill Insurance / Medicaid

_____ (*initial*) I have received a copy of the **NC ITP System of Payment Notification**. The notifications related to billing private and public insurance benefits have been explained to me and I understand them.

_____ (*initial*) The insurance information on record for my child is current and accurate.

_____ (*initial if applicable*) I understand that if my child is covered by private insurance and Medicaid, private insurance must be billed first under Medicaid Policy, before Medicaid benefits can be accessed.

Check one of the following:

- I consent for the NC ITP and its authorized service providers to bill the private insurance and / or Medicaid on record for my child for all of the early intervention services as identified on this IFSP. I authorize the release of medical or clinical information necessary to process the insurance claim.
— OR —
- I consent for the NC ITP and authorized service providers to bill the private insurance and / or Medicaid, on record for my child, for the early intervention services identified on this IFSP **except** for the following (*please specify*) _____

Parent/Guardian Signature and Date

Parent/Guardian Signature and Date

EI Service Coordinator Signature and Date

Agency Representative or Designee Signature/Agency and Date

Other Signature and Date

Other Signature and Date

IX. IFSP Review

Summarize Review Results

REVIEW CYCLE Semi-Annual Annual Other Target Date for Next Review :

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Action Proposed: To initiate or change the services listed on the IFSP for which consent is provided, according to the Service Delivery Plan.
Reasons for Taking the Action: After discussing all assessment information, including family observation, concerns, priorities and resources, the IFSP team, including the family, agreed on the early intervention services and other supports to be provided to achieve the established outcomes.

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Check one of the following:

- I consent for the NC Infant-Toddler Program and service providers to provide the NC ITP services and activities identified on this IFSP.
- I decline for my child or family to receive: (specify) _____
— AND — _____
 I consent for the NC ITP and service providers to provide all other NC ITP services and to carry out all other activities listed on this IFSP, EXCLUDING the service or services I have specified here. _____

Consent to Bill Insurance / Medicaid

_____ (*initial*) I have received a copy of the **NC ITP System of Payment Notification**. The notifications related to billing private and public insurance benefits have been explained to me and I understand them.
 _____ (*initial*) The insurance information on record for my child is current and accurate.
 _____ (*initial if applicable*) I understand that if my child is covered by private insurance and Medicaid, private insurance must be billed first under Medicaid Policy, before Medicaid benefits can be accessed.

Check one of the following:

- I consent for the NC ITP and its authorized service providers to bill the private insurance and / or Medicaid on record for my child for all of the early intervention services as identified on this IFSP. I authorize the release of medical or clinical information necessary to process the insurance claim.
— OR —
- I consent for the NC ITP and authorized service providers to bill the private insurance and / or Medicaid, on record for my child, for the early intervention services identified on this IFSP **except** for the following (*please specify*) _____

Parent/Guardian Signature and Date

EI Service Coordinator Signature/ and Date

Other Signature and Date

Parent/Guardian Signature and Date

Agency Representative or Designee Signature/Agency and Date

Other Signature and Date