## Individualized Family Service Plan (IFSP)

### Child and Family Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Name (First/Middle/Last)</td>
<td></td>
</tr>
<tr>
<td>Birth Date</td>
<td></td>
</tr>
<tr>
<td>ID Number</td>
<td></td>
</tr>
<tr>
<td>MA Number</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>Home Phone</td>
<td></td>
</tr>
<tr>
<td>Parent/Guardian/Surrogate Name</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>Home Phone</td>
<td></td>
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<tr>
<td>Address</td>
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<tr>
<td>Work Phone</td>
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<tr>
<td>E-mail</td>
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<tr>
<td>Cell Phone</td>
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</tbody>
</table>

**Best Time to Contact:**

**Best Method of Contact:**

- [ ] Home Phone
- [ ] Work Phone
- [ ] Cell Phone
- [ ] 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.

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

### 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:**
**PART I - INFORMATION ABOUT MY CHILD’S DEVELOPMENT**  
Section A - Health Information

### General Health

What was your child’s gestational age at birth?  

<table>
<thead>
<tr>
<th>Weeks</th>
<th>Days</th>
</tr>
</thead>
</table>

What was your child’s birth weight?  

<table>
<thead>
<tr>
<th>Pounds</th>
<th>Ounces</th>
<th>Grams</th>
</tr>
</thead>
</table>

Who is your primary care physician or other health care professional?  

<table>
<thead>
<tr>
<th>Phone</th>
</tr>
</thead>
</table>

### 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, including specific diagnoses?
### PART I - INFORMATION ABOUT MY CHILD’S DEVELOPMENT

**Section B - Present Levels of Development**

#### Evaluation Status:
- Entry
- Interim (Birth to 3)
- Exit (Birth to 3)
- Interim (Age 3–4)
- Exit (Age 3–4)

#### Present Levels of Development

<table>
<thead>
<tr>
<th>Area</th>
<th>Date of Assessment (MM/DD/YY)</th>
<th>Name of Assessment Instrument(s)</th>
<th>Chronological Age</th>
<th>Age Level/Age Range</th>
<th>Qualitative Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication</td>
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</tr>
<tr>
<td>Social or Emotional</td>
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</tr>
<tr>
<td>Adaptive</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Fine Motor</td>
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<tr>
<td>Gross Motor</td>
<td></td>
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</tbody>
</table>

#### Hearing
- Did your child pass a Universal Newborn Hearing Screening? [ ] Yes [ ] No [ ] Not Applicable
- Has your child seen an audiologist for a full hearing evaluation? [ ] Yes [ ] No
- Are there any concerns about your child’s hearing? [ ] Yes [ ] No

#### Vision
- Has your child’s vision been tested? [ ] Yes [ ] No
- Are there any concerns about your child’s vision? [ ] Yes [ ] 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, Tay-Sachs 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: _________________________________________

Eligibility for Early Intervention Services (Part I, Section C) - Rev 5/10

MD IFSP 7/1/13
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.

### Concerns, Priorities, and Resources

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

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

- Locally developed family interview tool
- Ages and Stages Questionnaire (ASQ)
- Routines-Based Interview (RBI)
- Other tools/methods: ____________________________

☐ Family declined family-directed assessment.
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:

- Child’s home
- Child care center
- Religious setting
- Family child care
- Early Head Start/Head Start
- Library
- Home of family member
- Toddler playgroup
- Judy Center
- Family Support Center
- Parent’s place of employment
- Shelter
- 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?
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.

<table>
<thead>
<tr>
<th>HOW DOES MY CHILD...</th>
<th>MY CHILD’S STRENGTHS</th>
<th>MY CHILD’S NEEDS</th>
<th>HOW DOES MY CHILD’S DEVELOPMENT RELATE TO HIS/HER SAME-AGE PEERS?</th>
</tr>
</thead>
</table>
| **DEVELOPING POSITIVE SOCIAL-EMOTIONAL SKILLS** | 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? | Has my child shown any new skills or behaviors related to positive social-emotional development since the last Strengths and Needs Summary?  
  ❑ Yes (include as “Strengths”)  
  ❑ No ❑ Not applicable |
| ▪ Attend to people?  
  ▪ Relate with family members?  
  ▪ Relate with other adults?  
  ▪ Relate with other children?  
  ▪ Display emotions?  
  ▪ Respond to touch? | | |
| **ACQUIRING AND USING KNOWLEDGE AND SKILLS** | | | Has my child shown any new skills or behaviors related to acquiring and using knowledge and skills since the last Strengths and Needs Summary?  
  ❑ Yes (include as “Strengths”)  
  ❑ No ❑ Not applicable |
| ▪ 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”? | | | |
| **TAKING APPROPRIATE ACTION TO MEET NEEDS** | | | Has my child shown any new skills or behaviors related to taking actions to meet needs since the last Strengths and Needs Summary?  
  ❑ Yes (include as “Strengths”)  
  ❑ No ❑ Not applicable |
| ▪ 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? | | | |
| OTHER | | | |
Based upon information from your child’s present levels of development and shared reports, your child’s strengths and needs, your family’s concerns, priorities, and resources, and your daily routines, this plan outlines what we want to accomplish and the specific steps required. Please discuss your priority outcomes for your child and/or family, including specific skills and context. A separate “Child and Family Outcomes” form is completed for each outcome.

<table>
<thead>
<tr>
<th>OUTCOME</th>
<th>STRATEGIES/ACTIVITIES/LEARNING OPPORTUNITIES</th>
<th>MEASURABLE CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>What would we like to see happen?</td>
<td>What steps need to be taken to help accomplish the priority outcome?</td>
<td>How will we know when the outcome is achieved?</td>
</tr>
</tbody>
</table>

TRANSITION OUTCOME
[ ] Yes  [ ] No

EDUCATIONAL OUTCOMES ADDRESSED (at age 3 or older)
[ ] Language  [ ] Numeracy  [ ] Pre-literacy

TIMELINE

PARTICIPANTS - Who will be involved?

<table>
<thead>
<tr>
<th>Name:</th>
<th>Title:</th>
<th>Phone/E-mail:</th>
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<tbody>
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</tbody>
</table>

OUTCOME PROGRESS REVIEW

Review Codes: Select the code that best applies.

1- Proficient - We did it!
2- In process - We’re making progress.
3- Needs development - Let’s make adjustments.
4- No longer needed
5- Postponed

<table>
<thead>
<tr>
<th>Code:</th>
<th>Date:</th>
<th>Initials:</th>
<th>Comments:</th>
</tr>
</thead>
</table>

OUTCOME PROGRESS RESPONSE - (ONLY NEEDED FOR PROGRESS REVIEW CODE 3)

Review Codes: Select the code that best applies.

1- Revise outcome
2- Modify strategies/activities
3- Change service
4- Other: ___________________________

<table>
<thead>
<tr>
<th>Code:</th>
<th>Date:</th>
<th>Initials:</th>
<th>Comments:</th>
</tr>
</thead>
</table>
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

- Please specify:

<table>
<thead>
<tr>
<th>Number of Sessions</th>
<th>Method of Service Delivery</th>
<th>Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Length</td>
</tr>
<tr>
<td>Only</td>
<td>Daily</td>
<td></td>
</tr>
<tr>
<td>Daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weekly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monthly</td>
<td></td>
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<tr>
<td>Yearly</td>
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<td></td>
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<tr>
<td>Quarterly</td>
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<tr>
<td>Semi-Annually</td>
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</table>

- Other:

<table>
<thead>
<tr>
<th>Number of Sessions</th>
<th>Method of Service Delivery</th>
<th>Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Length</td>
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</table>

Discussion of Early Intervention Service Delivery:

**Type of Service**

- Audiology
- Family Counseling
- Training
- Health
- Medical (diagnosis & evaluation only)
- Nursing
- Nutrition
- Occupational Therapy
- Physical Therapy

- Psychological
- Respite Care
- Sign Language/Cued Language
- Social Work
- Special Instruction
- Speech/Language Therapy
- Vision Services
- Other

**Community-Based Settings**

- 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

- Grocery store
- Park/Playground
- Restaurant
- Community/Recreation Center
- Parent's place of employment
- Shelter
- Other

- Early Intervention Center/Class for Children with Disabilities
- Service Provider Location (e.g., Outpatient, Audiologist)
- Hospital (Inpatient)
- Residential facility
- Other

**Setting**

- Home (Principal residence of child's family or caregivers)
- Community-Based Setting (Please specify):
- Other (Please specify):

Justification for Other Setting:

**Other Settings**

- Early Intervention Center/Class
- Service Provider Location
- Hospital (Inpatient)
- Residential facility
- Other

**Other Settings (Not community or home-based)**

**Financial Responsibility:** Check one agency responsible for payment of services.

- Local School System
- Local Health Department
- Local Department of Social Service
- Other (Please specify):

**Reimbursement Source:** Check one reimbursement source only when the agency designated as financially responsible intends to request payment for the service from another source.

- Medical Assistance
- Maryland School for the Blind
- Maryland School for the Deaf
- Other (Please specify):

**Provider Agency:** Record the name of the agency providing the service. Use the standard text designation within each agency.

**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.

**Projected Service Review Date:** Record the projected date on which the service will be reviewed.

**Projected Duration:** Record the time period that the service will be provided.

**Service Ending Date:** Record the date on which the service ends.
## Early Intervention Services (continued)

### Services for Children Who Are Blind/Visually Impaired or Deaf/Hearing Impaired

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were parents provided information regarding the Maryland School for the Blind?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were parents provided information regarding the Maryland School for the Deaf?</td>
<td></td>
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</tr>
</tbody>
</table>

### Assistive Technology

Does my child need assistive technology services or devices to increase, maintain, or improve his/her functional capabilities?  

**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:  

### Transportation

Does this plan include the transportation necessary to enable my child and/or family to receive early intervention services?  

**Types of Transportation**

- Parent with reimbursement  
- School Bus  
- Taxi  
- Public Transportation with reimbursement  
- Other (Please Specify) _____________________________________________________________________

Is any special equipment needed for transporting my child?  

If YES, specify the type of equipment:  

**Provider**

Provider Name:  
Phone:  
E-mail:
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.)**

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

<table>
<thead>
<tr>
<th>Provider Name:</th>
<th>Provider Name:</th>
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<tbody>
<tr>
<td>Phone/E-mail:</td>
<td>Phone/E-mail:</td>
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<td>Phone/E-mail:</td>
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</tbody>
</table>

**STRATEGIES TO HELP SECURE SERVICE LINKAGES FOR THE FAMILY**

**PAYMENT SOURCES (Check all that apply.)**

- Health Maintenance Organization (HMO)
- Medical Assistance
- No fee
- Other Health Insurance
- Parent: Full Payment
- Parent: Sliding Fee
- Other: ________________________________________

<table>
<thead>
<tr>
<th>Name:</th>
<th>Name:</th>
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<tbody>
<tr>
<td>Title:</td>
<td>Title:</td>
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<td>Phone:</td>
<td>Phone:</td>
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<tr>
<td>E-mail:</td>
<td>E-mail:</td>
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</tbody>
</table>
PART VI - AUTHORIZATION(S)
Section A – IDEA Consent

Authorization(s)

PARENT/GUARDIAN/SURROGATE CONSENT

- 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
Parental consent must be obtained before the provider agency discloses, for billing purposes, their child’s personally identifiable information to the Maryland Department of Health and Mental Hygiene (DHMH), the State agency responsible for the administration of the Medical Assistance (MA) Program, consistent with the Family Educational Rights and Privacy Act (FERPA) and the Individuals with Disabilities Education Act (IDEA). By providing consent, you understand and agree in writing that the public agency may access your child’s Medicaid to pay for services provided to your child.

In order to provide early intervention services to your child, the provider agency may not:

- Require you to sign up for or enroll in the State’s MA Program in order for your child to receive services under IDEA;
- Require you to incur an out-of-pocket expense such as the payment of a deductible or co-pay amount incurred in filing a claim for services;
- Use your child’s benefits under Medical Assistance if that use would:
  ° Decrease available lifetime coverage or any other insured benefit,
  ° Result in your family paying for services that would otherwise be covered by Medical Assistance and that are required for your child outside of the time your child is in school,
  ° Increase premiums or lead to the discontinuation of benefits or insurances, or
  ° Risk loss of eligibility for home and community-based waivers, based on aggregate health-related expenditures.

You have the right to withdraw your consent to disclosure of personally identifiable information to State’s Medical Assistance Program at any time. If you withdraw consent for the provider agency to disclose your child’s personally identifiable information it does not relieve the provider agency of its responsibility to ensure that all required services are provided to your child at no cost to parent.

Is the child eligible for MA?  □ Yes  □ No  MA Number __________________________________________

- I agree to Early Intervention Services Case Management and that the Service Coordinator(s) identified on this IFSP may be appointed as MA Service Coordinator(s) (COMAR 10.09.40). I understand that I am free to choose an MA Service Coordinator for my child. At this time, I accept the following Service Coordinator(s):

  MA Service Coordinator Name ________________________________________________

  MA Service Coordinator Name ________________________________________________

- I understand that if I wish to change the MA Service Coordinator in the future, I can call the early intervention program to make a change.
- I understand that the purpose of this service is to assist in gaining access to needed medical, social, educational, and other services.
- I give my consent for the provider agency to disclose my child’s personally identifiable information to the State’s Medical Assistance Program in order to access Medical Assistance Benefits.
- I 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 IFSP goals.
- I understand that if I refuse to allow the provider agency access to MA funds, it does not relieve the provider agency of its responsibility to ensure that all required services are provided to my child at no cost to parent.
- I understand that this service does not restrict or otherwise affect my child’s eligibility for other MA benefits. I also understand that my child may not receive a similar type of case management under MA if he/she qualifies for more than one type.

Parent(s)/Guardian/Surrogate Signature __________________________________________ Date __________

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

Transition At Age 3

EXPLANATION FOR MEETING DELAY

If the Transition Planning Meeting is **held after the child has reached 33 months of age**, check the response below that provides an explanation. *(Check only one.)*
- Attempts to contact family were unsuccessful.
- Child was referred at 31.5 months of age or later.
- Family requested to reschedule or delay the meeting.
- Other: ____________________________

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. *(Check only one.)*
- Attempts to contact family were unsuccessful.
- Child was referred at 34.5 months of age or later.
- Family declined to participate in the meeting.
- Other: ____________________________

CONSIDERATION OF ELIGIBILITY FOR PRESCHOOL SPECIAL EDUCATION AND RELATED SERVICES (PART B)

☐ Parents wish to consider Part B eligibility. ☐ Parents DO NOT wish to consider Part B eligibility.

COMMUNITY SERVICES

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

**Developmental/Medical/Health:**
- Developmental Therapies (other than Part C and Part B)
- Equipment/Devices
- Home Health Care
- Immunizations
- Mental Health Services
- Primary Health Care
- Women, Infants, and Children (WIC) Program

**Child Care/Enrichment:**
- Camps
- Family Day Care
- Group Child Care
- Head Start
- Even Start
- Play Group
- Preschool Program:
  - Public
  - Private
- Recreation Program
- Judy Center
- Home Instruction for Parents of Preschool Youngsters (HIPPY)

**Family Support:**
- Family Support Center
- Home Visiting Program (Please specify)
- Parent Education
- Support Group
- Other: ____________________________

Other Community Services:
  __________________________________
  __________________________________
  __________________________________

TRANSITION PLANNING MEETING NOTES/FUTURE STEPS

<table>
<thead>
<tr>
<th>Activities</th>
<th>Timelines</th>
<th>Person(s) Responsible</th>
</tr>
</thead>
</table>

RESULTS OF THE INITIAL IEP ELIGIBILITY DETERMINATION MEETING (TO BE COMPLETED BY SPECIAL EDUCATION STAFF)

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

☐ The child is determined to be **ELIGIBLE** for ongoing services through an IFSP or preschool special education and related services through an IEP.

☐ The child is determined to be **INELIGIBLE** for ongoing services through an IFSP or preschool special education and related services through an IEP.
### CONSIDERATION OF SPECIAL EDUCATION AND RELATED SERVICES (PART B)

**Prior to the beginning of the school year following the child’s 4th birthday:**
- 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 the beginning of the school year following the child’s 4th birthday:**
- 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.

### COMMUNITY SERVICES

<table>
<thead>
<tr>
<th>Developmental/Medical/Health:</th>
<th>Child Care/Enrichment</th>
<th>Family Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Therapies (other than Part C and Part B)</td>
<td>Camps</td>
<td>Family Support Center</td>
</tr>
<tr>
<td>Equipment/Devices</td>
<td>Even Start</td>
<td>Home Visiting Program (Please specify)</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Family Day Care</td>
<td></td>
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<tr>
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<tr>
<td>Women, Infants, and Children (WIC) Program</td>
<td>Judy Center</td>
<td>Other:</td>
</tr>
</tbody>
</table>

Other Community Services:

- [ ] Public
- [ ] Private
- [ ] Recreation Program

### TRANSITION PLANNING MEETING NOTES/FUTURE STEPS

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**Transition After Age 3**

**EXPLANATION FOR TRANSITION PLANNING MEETING DELAY**

If the transition planning meeting is held **later than 90 days prior to when the child is no longer eligible**, check the response below that provides an explanation. *(Check only one.)*
- Attempts to contact family were unsuccessful
- Family requested to reschedule or delay the meeting
- Other: ____________________________

If the transition planning meeting was **not held at all prior to when the child was no longer eligible**, check the response below that provides an explanation. *(Check only one.)*
- Attempts to contact family were unsuccessful
- Family chose IEP services prior to 90-day timeline
- Family declined to participate in the meeting
- Other: ____________________________

**TRANSITION PLANNING MEETING DATE**

**PART VII - MY CHILD’S TRANSITION INFORMATION**

Section B - Transition After Age Three

---

**CONSIDERATION OF SPECIAL EDUCATION AND RELATED SERVICES (PART B)**

**Transition Planning Meeting Date**

**EXPLANATION FOR TRANSITION PLANNING MEETING DELAY**

If the transition planning meeting is held later than 90 days prior to when the child is no longer eligible, check the response below that provides an explanation. *(Check only one.)*
- Attempts to contact family were unsuccessful
- Family requested to reschedule or delay the meeting
- Other: ____________________________

If the transition planning meeting was not held at all prior to when the child was no longer eligible, check the response below that provides an explanation. *(Check only one.)*
- Attempts to contact family were unsuccessful
- Family chose IEP services prior to 90-day timeline
- Family declined to participate in the meeting
- Other: ____________________________

**COMMUNITY SERVICES**

Is the family being referred to community services?  

- [ ] Yes  
- [ ] No  

*If YES, check the services that apply.*

**TRANSITION PLANNING MEETING NOTES/FUTURE STEPS**

<table>
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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 understand that if I/we choose 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 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

Service Coordinator

Other Participant

Other Participant

Child Name: | ID Number: | IFSP Meeting Date:

PART VIII - PARENT CONSENT (At or Before Age Three)

Family Choice: Consent to the Continuation or Request Termination of IFSP Services
CHANGES TO CHILD AND FAMILY INFORMATION

(Changes to demographic information do NOT require a parent signature.)

CHILD INFORMATION:

Child’s Name: ________________________________________________

Address: _____________________________________________________

Phone: _______________________________________________________

Birth Date: ___________________________________________________

Medical Assistance #: _________________________________________

FAMILY INFORMATION:

Name: _________________________________________________________

Address: _____________________________________________________

Phone: _______________________________________________________

E-mail: _______________________________________________________

Relationship to Child: _________________________________________

SERVICE COORDINATOR INFORMATION:

Name: _________________________________________________________

Agency: _______________________________________________________

Phone: _______________________________________________________

E-mail: _______________________________________________________

REVIEW TYPE: Select one.

MEETING DATE: ___________________________________________________________________________________

q Six Month
q Annual Review
q Provider Request
q Parent Request
q Parent/Provider Request

REVIEW STATUS: Select one to continue, modify or end the IFSP.

q Continue IFSP
q Modify IFSP: Select all that apply.
   □ Service Addition
   □ Service Modification
   □ Service Ending
   □ Add/Modify Outcomes
   □ Transition Planning-At Age 3
   □ Transition Planning-After Age 3
q End IFSP: If selected, complete the “REASON FOR INACTIVE STATUS” selection below.

REASON FOR INACTIVE STATUS: Select one.

INACTIVE DATE: ___________________________________________________________________________________

q Attempts to contact were unsuccessful (Birth–Age 4)
q Completion of IFSP prior to reaching age three (Birth to 3)
q Deceased (Birth–Age 4)
q Determined ineligible-child was never eligible (Birth to 3)
q Determined ineligible-screening only (Birth to 3)
q Moved out of State (Birth–Age 4)
q Moved to another jurisdiction (Birth–Age 4)
q Parent withdrawal (Birth–Age 4)
q Transition at age three-not continuing on an IFSP (Birth to 3)
q Transition after age three (Age 3–Age 4)
q Completion of IFSP after age three (Age 3–Age 4)
q Transition at the beginning of the school year following the 4th birthday

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 given 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

Add/Change Form - Rev 5/13