



- Screening Only**
(sections 1-3) _____
Date _____
- Evaluation Only**
(sections 1-5) _____
Date _____
- Full IFSP**
(sections 1-14) _____
Date _____

Individualized Family Service Plan (IFSP) Process Document (PD)

Educational and Developmental Intervention Services
Early Intervention Services
EDIS Location: _____

For use of this form see, MEDCOM Reg 40-53 ; the proponent agency is MCHO-CL-H

1. General Information

Child's name: _____ Boy Girl Date of Birth: _____ Age: _____ Gestational Age: _____

Parents/Guardians Name: _____

Initial Referral Date: _____

Annual re-evaluation

Referral Source: _____

When did you arrive at this duty station? _____

Expected departure from this duty station? _____

Service Coordinator (initial ongoing): _____

Early intervention recognizes that parents know their child best. We value your input and will include you in every step.

Please describe your expectations for your involvement in early intervention.

What is the best way for Early Intervention to share information with you? (written, demonstration, discussion, etc)

2. Family Questions/Concerns - Reason for Referral

- Please describe the questions/concerns you have about your child's development.
- Describe what is happening now and what you would like your child to be doing.

Child's Name: _____

3. Screening

Functional Vision & Hearing Screening:

Does the child: (Y=yes; N=no; N/A=not applicable)

- Make eye contact with adults
- Follow a moving object with eyes
- Make eye contact with toys, tasks, or objects
- Hold objects at a normal distance (after 6 months)
- Look at people/things without crossing or squinting eyes
- Look at people and things without covering one eye
- Walk without frequently bumping into objects
- Walk smoothly across shadows that look different
- Have eyes that are clear and not red or watery

Is there a family history of vision impairment?

- No Yes (explain)

Has your child had his/her vision checked before?

- No Yes (explain)

Do you have questions/concerns about your child's vision?

- No Yes (explain)

Does the child: (Y=yes; N=no; N/A=not applicable)

- Raise eyebrows to sounds (bell, other noise) (until 4 months)
- Startles to loud noises (until 6 months)
- Show awareness of noises, door knock, television, toys...
- Imitate sounds (after 1 year)
- Use a voice that is no too loud or too soft
- Listen to stories, records, CDs, or TV without difficulty
- Come to you when called from a distance (after 8 months)
- Use some word endings "s" or "ing" (after 2 years)
- Speak so most people can understand (after 2 ½ yrs.)
- Has history of ear infections

Is there a family history of hearing loss?

- No Yes (explain)

Has your child had his/her hearing checked before?

- No Yes (explain)

Do you have questions/concerns about your child's hearing?

- No Yes (explain)

Developmental Screening

Date: _____

Annual re-evaluation – Developmental Screening not required.

Screening instrument, observations, and results

No further evaluation at this time Further evaluation recommended

Re-screen recommended (indicate date/timeframe for re-screening) _____

Parent/s Signature: _____ Date _____

Screeener's Signature: _____ Date _____

Child's Name:

4 Health Information

Where do you take your child for health care?

Who is your child's primary care manager (PCM) or provider?

Child's Current Health: Date and results of most recent well baby exam (refer if more than 6 months ago).

Other health information relevant to the referral. For Example: diagnosis; prenatal complications; birth complications; weight gain concern; developmental milestones; illnesses; allergies/medications, frequent trips to the ER or clinic; other information.

Are there any questions/concerns about: Pain, Dental, Nutrition, Sleeping, Behavior *(If yes please explain)*.

Pain your child may have? No Yes

Your child's eating/nutrition/growth? No Yes

Your child's sleeping? No Yes

How does your child express pain?

Your child's oral/dental health? No Yes

Your child's behavior? No Yes

Is there any family health history or mental health information that would be useful for us to know?

The team recommends the following referrals be discussed with the PCM/provider (describe who will do what):

5. Developmental Evaluation and Eligibility Status

Methods & Procedures: family report natural observation standardized evaluation criterion referenced assessment

General observations: Were special arrangements/adaptations needed? Child's health and behavior, etc.?

Child's Name:

Results

Domains	Instruments, Dates & Results
Adaptive/Self-help	
Social/Emotional	
Communication	
Physical Motor	
Cognitive	
Other	

Summary Address family concerns. Summarize information gathered to this point, include evaluation findings & information needed to assist with eligibility determination. Identify child strengths & needs. Describe next steps in the process & any major recommendations.

Eligibility Status: Complete MEDCOM Form 720 "Report of Eligibility" for initial eligibility determination and when eligibility status changes

Child's Name _____ is is not continues to be eligible for early intervention services.

Signatures

Printed name	Signature	Discipline/Family Role
Names of others who provided information included in this document		Discipline/Family Role

Child's Name:

6. Family and Child Strengths and Resources

Early Intervention focuses on helping you help your child develop during his/her everyday activities with your family. To understand how we may be able to help; we'd like to learn more about your family and the activities you and your child enjoy and any activities or routines that may be difficult. The information you choose to share is voluntary.

- Please tell me a little about your family. Who lives at home with you and your child? Who else is involved (extended family, friends, service/support agencies/providers, community groups, work colleagues, etc.)?

- What is your child really good at? What does your child like to do (e.g., favorite toys, activities, people, places)?

- What do you and your child/family enjoy doing or consider fun parts of the day at home or in community?
- Are there things that you would like to do but are unable to?

- Are there any questions/concerns you have for your family regarding childcare, transportation, finance, safety, etc?
- Please tell me about work, or any current/pending deployments, or events that may affect your family.

- Is there anything about your cultural or spiritual beliefs that would be good for us to know in working with your family?

You must also complete MEDCOM Form 721A, Family and Child Routines and Activities Worksheet.

Child's Name:

7. Functional Abilities, Strengths, and Needs *(Present Levels of Development)*

- ♦ *Adaptive: (Eating, dressing, bathing, toileting, sleeping).*
- ♦ *Social/Emotional: (Interacting with others, learning to cope).*
- ♦ *Communication: (Understanding and talking).*
- ♦ *Physical Motor: Gross Motor (whole body movements) & Fine Motor (movement of small muscles & hands).*
- ♦ *Cognitive: (Playing, thinking, exploring, and understanding concepts).*

Describe the child's integrated skill development and functioning in terms of:

1. Social-emotional skills including social relationships.
2. Acquiring and using knowledge and skills.
3. Taking appropriate action to get needs meet.

Child's Name:

Functional Abilities, Strengths, and Needs (continued)

Child's Name:

8. Family Concerns and Priorities

Thinking of all the information we've gathered through the routines-based interview and other activities, let's record the concerns/desires you have for your child and family that you would like to address through early intervention. Together, we'll use this information to develop functional outcomes. Outcomes describe what you would like to see happen for your child and family as a result of your involvement with early intervention. After the desires/concerns are identified, please prioritize them.

(Sometimes the family may choose to address identified needs at a later time. Identify areas of need that may be addressed later.)

Priority	Desires/Concerns	What's happening now?	Outcome

Child's Name: _____

9. Outcomes

Initial/Annual Addition Date: _____

Outcome # _____ (*♦What we would like to see happen? ♦When, where, or with whom? ♦What will be better?*)

Strategies to Reach the Outcome

(*♦Who will do what? ♦ Consider what is currently in place. ♦ Consider child/family interests, routines, activities*)

Achievement of the Outcome

Criteria: We'll know the outcome is achieved when: (*♦What will be observed? ♦ Where/with whom? ♦ When/how often?*)

Procedures: Achievement of & progress toward the outcome will be measured by: (*♦Who will do what?*)

Timeline: Progress will be reviewed in:

Outcome Review

No Change _____
Dates

Making progress _____
Dates

Met _____
Dates

Outcome Status: Continue _____
Dates

Discontinue _____
Dates

Modify _____
Dates

Child's Name:

10. Transition

Initial/Annual Addition Revision

Type of Transition

Anticipated Date of Transition

Steps to be taken to support the transition:

11. Other Services

Transportation (specify below)

Assistive Technology (specify below)

12. Support Service

Describe support services EDIS will provide and how they will be provided.

Describe relevant services the family needs or receives from other agencies. Include who will do what to pursue the needed services.

Child's Name:

13. Services

Service		Provided by		Outcome	<input type="checkbox"/> Initial/Annual <input type="checkbox"/> Addition
<input type="checkbox"/> Individual <input type="checkbox"/> Consultation <input type="checkbox"/> Group <input type="checkbox"/> Monitor	Frequency (how often) _____ For a minimum of _____ sessions	Intensity (time/session)		Location	
Start Date:		End Date:		<input type="checkbox"/> Discontinued Date:	
Additional information: including justification if services are not provided in the natural environment and description of any co-visits					

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Child's Name:

14. IFSP Agreement

Initial Annual

Date IFSP Developed:

Projected Review Date:

Service Coordinator:

Next Service Plan Date:

IFSP Team Members and Signatures

Attendee's Name	Specialty/Relationship to Child	Signature

Other Contributors Not Present (signature not required)

Parent(s) Statement

- Yes No I have received a copy of Procedural Safeguards and Due Process Procedures.
- Yes No This information has been explained to me and I understand it.
- Yes No I have participated as a team member in the development of this IFSP for my child and family.
- Yes No As a full member of the team I am in agreement with this IFSP.

Parent/Guardian Signature _____

Parent/Guardian Signature _____

Date _____

IFSP Review/Change Dates (see IFSP Review/Change form/s)

Child's Name:

13. Services

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9. Outcomes

Initial/Annual Addition Date: _____

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Strategies to Reach the Outcome

(*♦Who will do what? ♦ Consider what is currently in place. ♦ Consider child/family interests, routines, activities*)

Achievement of the Outcome

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Procedures: Achievement of & progress toward the outcome will be measured by: (*♦Who will do what?*)

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Dates

Making progress _____
Dates

Met _____
Dates

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