



- 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: _____	<input type="checkbox"/> Boy	<input type="checkbox"/> Girl	Date of Birth: _____	Age: _____	If born early enter Gestational Age: _____
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Parents/Guardians Name: _____

<input type="checkbox"/> Initial Referral Date: _____	<input type="checkbox"/> Annual re-evaluation
Referral Source: _____	

When did you arrive at this duty station? _____	Expected departure from this duty station? _____
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Service Coordinator (initial ongoing): _____

EDIS recognizes that parents know their child best. We value your input and will include you in every step.
 The "EDIS Early Intervention Services" tri-fold was reviewed with your family.

What is the best way for EDIS to share information with you (written, demonstration, discussing).

2. Family Questions/Concerns - Reason for Referral

- Please describe the reason for referral and questions/concerns you have about your child's development.
- Describe what is happening now as well as what you wish or think your child should be doing.

Child's Name: _____

3. Screening

Functional Vision & Hearing Screening:

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

Make eye contact with adults
 Follow a moving object with eyes
 Make eye contact with task or object
 Hold objects at a normal distance (after 6 months)
 Look at people/things without crossing or squinting eyes
 Walk without frequently bumping into objects
 Walk smoothly across shadows that look different
 Have eyes that are clear and not red or watery
 Have eyes that do not seem unusual (e.g., cross or turn in/out)

Does the child: (Y=yes; N=no; S=sometimes; 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 not too loud or too soft
 Come to you when called from a distance (after 18 months)
 Speech is at least 50% understandable (after 2 years)
 Has no history of ear infections
If child has had ear infections, how many? _____

Is there a family history of vision impairment from a young age?
 No Yes (explain) _____

Is there a family history of hearing loss from a young age?
 No Yes (explain) _____

Has your child had his/her vision checked before?
 No Yes (explain) _____

Has your child had his/her hearing checked before?
 No Yes (explain) _____

Do you have questions/concerns about your child's vision?
 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?
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Child's Current Health: Date and results of most recent well baby exam (refer to PCM if more than 6 months ago).

Other health information relevant to the referral. For Example: diagnosis, birth complications, weight gain, developmental milestones (e.g., sitting, crawling, walking, talking), illness, allergies/medications, frequent trips to the ER or clinic; other

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

Pain your child may have? <input type="checkbox"/> No <input type="checkbox"/> Yes	How does your child express pain?
Your child's eating/nutrition/growth? <input type="checkbox"/> No <input type="checkbox"/> Yes	Your child's oral/dental health? <input type="checkbox"/> No <input type="checkbox"/> Yes
Your child's sleeping? <input type="checkbox"/> No <input type="checkbox"/> Yes	Your child's behavior? <input type="checkbox"/> No <input type="checkbox"/> Yes

Is there any family health history, learning disability, 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

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

Child's Name:

Summary

Summarize information gathered that will assist with the eligibility decision. Include evaluation findings for all domains, general observations, descriptions of any arrangements or adjustments needed.

Methods:

family report

natural observation

standardized evaluation

criterion referenced assessment

Child's Name: _____

Eligibility Status: Initial Annual Supplemental

Initial Eligibility Determination (Complete this section for initial eligibility.)

_____ (Child's Name) is is not eligible for early intervention services.

If eligible: This child's eligibility is based on the following:

Developmental Delay: (Specify standard deviation or percentage of delay under areas of delay)

An MC Form 808 "Informed Opinion" was completed to estimate the developmental delay Yes No

<input type="checkbox"/> Adaptive	<input type="checkbox"/> Social - Emotional	<input type="checkbox"/> Communication	<input type="checkbox"/> Physical Motor	<input type="checkbox"/> Cognitive
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Biological Risk: (specify) _____

o Family does does not want early intervention services.

Tracking: If not eligible, will the child be placed in Tracking Yes No _____ (frequency)

Annual IFSP Eligibility Status (Complete this section as part of annual IFSP or supplemental eligibility).

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

Team Members

Meeting Date: _____

Printed name	Discipline/Family Role	Signature

Others contributors:

Discussion:

Parent(s) Statements

- Yes No I have received a copy of Procedural Safeguards and Due Process Procedures.
- Yes No I received my Notice of Proposed Action for the evaluation and eligibility.
- Yes No This information has been explained to me and I understand it.
- Yes No I have participated as a team member in determining eligibility for my child.
- Yes No I am in agreement with the team decision.

PRIVACY ACT STATEMENT: In accordance with the Privacy Act of 1994 (Public Law 93-579) 32 CFR Part 310, this notice informs you of the purpose of this form and how the information will be used. Please read it carefully.

AUTHORITY: The Individuals with Disabilities Education Act as amended by Public Law 102-119; DODI 1342.12; Record System Code A0040-66bDASG.

PRINCIPAL PURPOSES: This form collects information which is essential to determine eligibility for Army Educational and Developmental Intervention Services (EDIS). No personal or protected health information contained in EDIS records will be disclosed to any third party without specific written permission of the individual(s), unless required by statute or law.

ROUTINE USES: The information will be used to develop a service plan and deliver appropriate services to eligible families

DISCLOSURE: Voluntary. Failure to provide certain information necessary to determine eligibility may result in denial of services.

Child's Name:

6. Family and Child Strengths and Resources

What is your child really good at doing? (What does he/she enjoy doing? What makes him/her smile/laugh?)

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 would like to learn more about your family's strengths and resources. 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.)?

Are there any questions/concerns you have for your family regarding childcare, transportation, finance, safety, etc?

Anything about your family, culture, or spiritual beliefs which would be good for us to know in working with your family?

Please tell me about work, or any current/pending deployments, or events that may affect 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)*

As part of the evaluation we looked at five domains of development (adaptive, social/emotional, communication, physical/motor, and cognitive). To understand your child's functional abilities, strengths, and needs we gathered more information from you about your child and family's day to day routines and activities. Children's functional abilities overlap domains of development so we combine them into the following three functional outcome areas.

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

In addition to considering your child's functioning, relative to these three areas, we will identify with you how your child is functioning relative to other children his/her age. This information not only helps us help you support your child's development, it helps us understand how children benefit from participation in our early intervention services.

The Tri-fold "Measuring Results in Early Intervention Services: Understanding How Children and Families Benefit from Early Intervention" further describes how we measure the benefits of early intervention for children and families. This tri-fold was reviewed with your family.

Describe the child's integrated skill development and functioning in terms of the 3 functional areas:

Child's Name:

Functional Abilities, Strengths, and Needs (continued)

Child's Name:

8. Family Concerns and Priorities

Thinking of all the information we have gathered through the routines-based interview and other activities, let's record the concerns and desires you have for your child and family that you would like to address through early intervention. Together, we will 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.

Concerns/Desires	Priority	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?)

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

Procedures: Progress will be measured by: (♦ Who will do what?) **Timeline:** Progress reviewed in: (♦ When?)

Outcome Review

- No Change
- Making Progress
- Met

Plan: Continue Discontinue

Date:

Outcome Review

- No Change
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Plan: Continue Discontinue

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Child's Name:

10. Transition

Types of Transition (identify at least one of the four transition types below) **Anticipated Date:**

(1) Moving from catchment area

(2) Other (explain)

Steps to be taken to support the transition: (1) or (2):

(3) Transition at 3 years of age

Anticipated Date:

Steps to be taken to support the transition for a child turning 3 years of age:

Discuss transition options with the family

Help family learn about preschool options

For children who may be eligible for Special Education Part B Preschool Services EDIS will:

With parent permission send referral information to the local school (at least 90 days before child turns 3)

Assist family with local school registration as needed

Attend local school transition conference

Coordinate and assist with assessment as needed for the transition

Participate in eligibility and/or IEP meeting if appropriate

Other (explain)

(4) Transition discussed and no known transitions are anticipated within the next 12 months

11. Other Services

Transportation is needed for the family to participate in early intervention.

No Yes (if yes specify)

Assistive Technology (AT) is needed to achieve outcome/s _____ (explain what is needed)

AT may be tried with outcome/s _____ (see progress notes for details)

No AT needs at this time

12. Support Service

Identify services the child/family is receiving through other (non EDIS) sources.

Identify other non EDIS services the child/family need. Describe who will do what to help the family in access the service.

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: _____ Discontinued Date: _____

Additional information: including justification if services are not provided in the natural environment and description of any co-visits

Service	Provided by	Outcome	<input type="checkbox"/> Initial/Annual <input type="checkbox"/> Addition
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Additional information: including justification if services are not provided in the natural environment and description of any co-visits

Child's Name:

14. IFSP Agreement

Date IFSP Developed:

Projected Review Date:

Service Coordinator:

Next Service Plan Date:

Parent(s) Statements

- Yes No I have received a copy of Procedural Safeguards and Due Process Procedures.
- Yes No I received Notice of Proposed Action for the IFSP Development.
- 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.

IFSP Team

Implementation Date: _____

Printed Name	Discipline/Family Role	Signature

Discussion

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

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	
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Initial/Annual Addition Date: _____

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

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

Procedures: Progress will be measured by: (♦ Who will do what?) **Timeline:** Progress reviewed in: (♦ When?)

Outcome Review

- No Change
- Making Progress
- Met

Plan: Continue Discontinue

Date:

Outcome Review

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

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

Procedures: Progress will be measured by: (♦ Who will do what?) **Timeline:** Progress reviewed in: (♦ When?)

Outcome Review

- No Change
- Making Progress
- Met

Plan: Continue
 Discontinue

Date:

Outcome Review

- No Change
- Making Progress
- Met

Plan: Continue
 Discontinue

Date:

Outcome Review

- No Change
- Making Progress
- Met

Plan: Continue
 Discontinue

Date:

Outcome Review

- No Change
- Making Progress
- Met

Plan: Continue
 Discontinue

Date:

Outcome Review

- No Change
- Making Progress
- Met

Plan: Continue
 Discontinue

Date:

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?*)

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

Procedures: Progress will be measured by: (*♦ Who will do what?*) **Timeline:** Progress reviewed in: (*♦ When?*)

Outcome Review

- No Change
- Making Progress
- Met

Plan: Continue Discontinue

Date:

Outcome Review

- No Change
- Making Progress
- Met

Plan: Continue Discontinue

Date:

Outcome Review

- No Change
- Making Progress
- Met

Plan: Continue Discontinue

Date:

Outcome Review

- No Change
- Making Progress
- Met

Plan: Continue Discontinue

Date:

Outcome Review

- No Change
- Making Progress
- Met

Plan: Continue Discontinue

Date:

Outcomes

Initial/Annual Addition Date: _____

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

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

Procedures: Progress will be measured by: (*♦ Who will do what?*) **Timeline:** Progress reviewed in: (*♦ When?*)

Outcome Review

- No Change
- Making Progress
- Met

Plan: Continue Discontinue

Date:

Outcome Review

- No Change
- Making Progress
- Met

Plan: Continue Discontinue

Date:

Outcome Review

- No Change
- Making Progress
- Met

Plan: Continue Discontinue

Date:

Outcome Review

- No Change
- Making Progress
- Met

Plan: Continue Discontinue

Date:

Outcome Review

- No Change
- Making Progress
- Met

Plan: Continue Discontinue

Date: