SUFFOLK COUNTY DEPARTMENT OF HEALTH SERVICES
DIVISION OF SERVICES FOR CHILDREN WITH SPECIAL NEEDS

INDIVIDUALIZED FAMILY SERVICE PLAN

Interim	**Meeting Date**	/	/
Initial	**Meeting Date**	/	/
Amendment	**Meeting Date**	/	/
6 Month Review	**Meeting Date**	/	/
Annual Review	**Meeting Date**	/	/
Transition Plan	**Meeting Date**	/	/

IFSP EFFECTIVE DATES FROM: / / *TO* / /

To be completed at the IFSP meeting with the participation of the parent(s) and IFSP members.

Child's Name: (Last) ______________ (First) ______________ (M.I.) ______ A.K.A. ______________

Date of Birth: ____/____/____ [ ] Female [ ] Male

The Legal Guardian of this child is: [ ] Parent [ ] Agency [ ] Other Legal Guardian (Specify) ______________

Child resides with: (Last) ______________ (First) ______________ (M.I.) ______

Relationship to child: [ ] Parent [ ] Foster Parent [ ] Guardian

Address: (Street) ______________ (City) ______________ NY (Zip Code) ______

Phone: (Home) ______________ (Work) ______________
Area Code Number Area Code Number

*If Child's Legal Guardian is Foster Care Agency**

Foster Placement Agency: ______________ **Caseworker:** ______________

Address: (Street) ______________ (City) ______________ NY (Zip Code) ______

Phone: (Work) ______________ (Fax) ______________
Area Code Number Area Code Number

****Complete information page (1A) for Foster Parent, Surrogate Parent and/or other parties legally entitled to receive documentation.***

IFSP Participants:	***Print Name***	***Title/Agency***	***Signature***
[ ] Parent [ ] Legal Guardian [ ] Foster Parent [ ] Surrogate Parent			
[ ] Agency			
[ ] Initial [ ] Ongoing Service Coordinator			
[ ] Evaluator [ ] Provider			
Early Intervention Official Designee			
[ ] Other ______________			

Distribution: ***Division: White*** ***Parent: Yellow*** ***Provider: Pink*** ***Service Coordinator: Gold***

Individualized Family Service Plan
FAMILY CONCERNS AND PRIORITIES

Child's Name: (First) (MI)
Date: ____/____/____

Please identify family members and/or significant individuals involved in the child's growth and development:

Family's description of resources and strengths: (e.g.: parent involvement; reliable transportation; medical insurance; use of community resources; supportive family, religious or community affiliations, etc.)

Parent(s) description of concerns and priorities:

Comments:

Individualized Family Service Plan

Child's Name: (Last)__________ (First)__________ (M.I.)____

Date: ____/____/____

Physical Development: Current status of child's vision; hearing; health; fine and gross motor abilities.

Cognitive: Thinking skills, how the child uses toys and explores and controls his/her environment.

Communication: Skills include child's ability to understand what is said to him or her, use of sound, words or gestures to let others know what he/she needs.

Social Emotional: How the child gets along with adults and peers, plays with others, gets used to a new place and expresses emotions.

Adaptive: Skills include sucking, eating solid foods, drinking from a cup and helping to dress themselves.

Suffolk County BSCD IFSP2.96 Form 2

18-0974. 4/96ps

Individualized Family Service Plan
CHILD AND FAMILY OUTCOMES

Child's Name: (Last)________________ (First)________________ (M.I.) ____
Date: ______/______/______

DESIRED CHANGE(S)/OUTCOME(S):

Strategies: Ideas and activities we will do to make the outcome(s) happen.	People Responsible (You may select more than one.)	Strategies: Ideas and activities we will do to make the outcome(s) happen.	People Responsible (You may select more than one.)
	[ ]Parent [ ]Spec. Ed. [ ]Sp. Path. [ ]PT [ ]OT [ ]Psych. [ ]______ [ ]______		[ ]Parent [ ]Spec. Ed. [ ]Sp. Path. [ ]PT [ ]OT [ ]Psych. [ ]______ [ ]______

How will we know we have been successful (Criteria, procedure, timeline):

DESIRED CHANGE(S)/OUTCOME(S):

Strategies: Ideas and activities we will do to make the outcome(s) happen.	People Responsible (You may select more than one.)	Strategies: Ideas and activities we will do to make the outcome(s) happen.	People Responsible (You may select more than one.)
	[ ]Parent [ ]Spec. Ed. [ ]Sp. Path. [ ]PT [ ]OT [ ]Psych. [ ]______ [ ]______		[ ]Parent [ ]Spec. Ed. [ ]Sp. Path. [ ]PT [ ]OT [ ]Psych. [ ]______ [ ]______

How will we know we have been successful (Criteria, procedure, timeline):

SUFFOLK COUNTY
DIVISION OF SERVICES FOR CHILDREN WITH SPECIAL NEEDS
IFSP SERVICE AGREEMENT

Child's Name: ______________________________ DOB: ______________

IFSP Dates: from ____________ to ______________ Amended on: ______________

Service Type	Rx Reqd.	Responsible Provider	Frequency / Duration	Method / Location	Start Date	End Date
Service Coordinator						

Parent/Guardian/Surrogate initials to indicate consent:

_____ I have been informed of and understand my rights and entitlements under the law, my right to review, access, amend my child's record and have received a copy of "Suffolk County's Notice of Child and Family Rights".
_____ I was informed in my native language (unless clearly not feasible to do so) or other mode of communication.
_____ I have participated in the development of this IFSP.
_____ I give my consent for Suffolk County Early Intervention Program EIOD, service coordinators, evaluators and service providers to have a copy of this IFSP.
_____ I consent to the confidential exchange of information regarding my child among my child's EIOD, service coordinators, evaluators and service providers.
_____ I consent to the confidential exchange of electronic data and documents contained within NYEIS, a secure, HIPPA compliant site.
_____ I understand this IFSP can be reviewed at my request.
_____ I have selected ______________________ as the Ongoing Service Coordinator. Phone # ____________
_____ I give permission for my child's caregiver ______________________ to review/sign ( ) provider attendance to review/sign ( ) log notes.
_____ I give permission for my child's pediatrician ______________________ to receive a copy of this IFSP.
_____ I give permission for the Chair of my child's CPSE ______________________ to receive a copy of this IFSP.
_____ I have, to the best of my knowledge, given the most recent health insurance information to SCDSCSN.
_____ Transition - Has ( ) Has Not ( ) been discussed.

Those services which are not in dispute will begin on the dates indicated on the IFSP.

[ ] I do not agree with the following aspects of the IFSP: ______________________

[ ] I am requesting: ______________________

______________________ ________ ______________________ ________
Parent/Guardian/Surrogate Signature (Circle one) | Date | EIOD Signature | Date

Method
A = Ind. /Group
B = Basic Group
C = Enhanced Group
Z = Ind. Center
H = Extended Home
D = Basic Group 1:1
E = Family Support Group
F = Support Group
G = Enhanced Grp 1:1

Location
A= Grp CC Ctr. / Nursery School
B = Family Day Care
C = Grp EI Ctr. (at least 1 hr-0% TD)
D = Grp EI Ctr./DCC (at least 1 hr 50% TD)
E = Home
F = Hospital
G = Provider Location
I = Residential
K = Comm Rec Site
M = CC Ctr. Individual

The next IFSP meeting date is ______________________