

## Michigan Individualized Family Service Plan

Referral Source to *Early On*: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_

**CHILD'S LEGAL NAME:** \_\_\_\_\_ **Current Residence:** \_\_\_\_\_

Date of Birth: \_\_\_\_\_ City of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_  M  F

Ethnic Heritage:  Asian American  Black or African American  American Indian or Alaska Native  
 Hispanic or Latino  White  Native Hawaiian or Pacific Islander

Child's present concerns and/or diagnosis: \_\_\_\_\_

School District of Residence: \_\_\_\_\_ County: \_\_\_\_\_

PARENT  GUARDIAN  FAMILY MEMBER  FOSTER PARENT

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: Day: \_\_\_\_\_ Evening: \_\_\_\_\_ Native Language/Mode of Communication: \_\_\_\_\_

Interpreter needed:  Yes  No Interpreter Provided:  Yes  No

PARENT  GUARDIAN  FAMILY MEMBER  FOSTER PARENT

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: Day: \_\_\_\_\_ Evening: \_\_\_\_\_ Native Language/Mode of Communication: \_\_\_\_\_

Interpreter needed:  Yes  No Interpreter Provided:  Yes  No

**PRIMARY HEALTH CARE PROVIDER:** \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

MEDICAL COVERAGE				BENEFIT STATUS					
	Yes	No	Pending	Number	Yes	No	Pending	Number	
Medicaid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	SSI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
CSHCS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	FSS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
MI Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____					
Private (primary)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____					
Private (secondary)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____					

**Other Family Members (Include name and relationship):** \_\_\_\_\_ **Other Health Providers:** \_\_\_\_\_


**Service Coordinator:** \_\_\_\_\_ Telephone: \_\_\_\_\_

SERVICES FAMILY CURRENTLY RECEIVES (CHECK ALL THAT APPLY)									
Education:	Start Date	End Date	Rec?	Plan Used	Mental Health:	Start Date	End Date	Rec?	Plan Used
Early On (Part C)			<input type="checkbox"/>	<input type="checkbox"/>	Family Support/DD Serv			<input type="checkbox"/>	<input type="checkbox"/>
Special Education (Part B)			<input type="checkbox"/>	<input type="checkbox"/>	Infant Mental Health/ Home Based Serv			<input type="checkbox"/>	<input type="checkbox"/>
<b>Public Health:</b>					<b>FIA:</b>				
WIC			<input type="checkbox"/>	<input type="checkbox"/>	Employment Services			<input type="checkbox"/>	<input type="checkbox"/>
CSHCS			<input type="checkbox"/>	<input type="checkbox"/>	Emergency Funds			<input type="checkbox"/>	<input type="checkbox"/>
Infant Support Services			<input type="checkbox"/>	<input type="checkbox"/>	Public Assistance			<input type="checkbox"/>	<input type="checkbox"/>
Immunizations			<input type="checkbox"/>	<input type="checkbox"/>	Child Care			<input type="checkbox"/>	<input type="checkbox"/>
<b>Community Services/Other:</b>					<b>Community Services/Other:</b>				
<b>Community Services/Other:</b>					<b>Community Services/Other:</b>				

### TYPE OF IFSP

Interim IFSP/Date \_\_\_\_\_  Initial IFSP/Date \_\_\_\_\_

**6 Month Review/Date** \_\_\_\_\_  **Annual/Date** \_\_\_\_\_

Other Review Date \_\_\_\_\_  Other Review Date \_\_\_\_\_

Special circumstances that delayed IFSP > 45 days after referral: \_\_\_\_\_

***Family Information***

If the family has given permission to an interview on the "Consent to Evaluation Form":

	Family Resources/Strengths	Family Concerns	Family Preferences
<u>MEDICAL/HEALTH</u> (Doctor, Insurance, Immunizations, Nutrition, Dental, Substance Use, Current Medications, Hearing, Vision, etc.)			
<u>EDUCATION</u> (Rehabilitation Services, Skill Development, School, Technical Training, College, etc.)			
<u>MATERIAL NEEDS</u> (Transportation, Housing, Utilities, Food, Clothing, etc.)			
<u>EMPLOYMENT/FINANCIAL</u> (Work, Income, Budgeting, etc.)			
<u>LEGAL</u> (Custody-Court Involvement, Legal-Aide, Child Support, Evictions, Civil Disputes, etc.)			
<u>SAFETY</u> (Physical Environment, Domestic Violence, Child Abuse/Neglect, Medical Issues and/or Mental Health Issues, etc.)			
<u>SOCIAL/LEISURE/SPIRITUAL</u> (Religious Organizations, Cultural, Recreational, Friends, etc.)			
<u>PSYCHOLOGICAL/EMOTIONAL</u> (Respite, Self Image, Family Relationships, Mental Health, Stress, etc.)			

**Rank Family Concerns/Needs by placing a number next to each item in order of priority, in the Family Concerns column.**

***Child's Current Developmental Status***

Informed clinical opinion to determine eligibility must be based on the integration of all 4 of the following sources of information. If eligibility was determined without any one or more of these sources, check appropriate box(es) and explain why that source was not used: \_\_\_\_\_

- Developmental History    Health Status    Observation of Parent and Child    Developmental Evaluation

***All parts of this table are required.***

Area	Present Level of Development		Method/Tool – Person Completing (Name/Title)	Family's Priorities
	Date/Parent Input	Date/Professional Input		
Health <input type="checkbox"/> see attached detail				
Hearing <input type="checkbox"/> see attached detail				
Vision <input type="checkbox"/> see attached detail				
Fine Motor <input type="checkbox"/> see attached detail				
Gross Motor <input type="checkbox"/> see attached detail				
Cognitive/ Thinking <input type="checkbox"/> see attached detail				
Communi- cation <input type="checkbox"/> see attached detail				
Social/ Emotional <input type="checkbox"/> see attached detail				
Adaptive/ Self-Help <input type="checkbox"/> see attached detail				

**Evaluation Planning:**

Where should it take place, and when? \_\_\_\_\_

If you could invite anyone, whom would you like to have present? \_\_\_\_\_

What would help you prepare for the evaluation? \_\_\_\_\_

Outcome # \_\_\_\_\_

**GOAL/OUTCOME STATEMENT** – What we would like to see happen for this child/family.

**PRESENT STATUS** – What is happening now?

**WHAT ARE THE STEPS** (objectives) to reach this outcome?

Expected Timeframe

Strategies/Methods for working on this outcome during this child and family's daily routines and activities. How will you know you have met the objective?

People who will be involved.

Explain how and why the child's outcome could not be met in the child's natural environment with supplementary supports, including options that have been explored.

<b>Service Code</b>	<b>Parent Initials</b>	<b>Frequency (How Often?) Intensity (How Long?)</b>	<b>Individual Or Group</b>	<b>Start Date</b>	<b>End Date</b>	<b>Location Code</b>	<b>Funding Code</b>

**Other Services**

To the extent appropriate, the IFSP must document services that are not required or covered under Part C. Listing the non-required services does not mean that those services must be provided, however, their identification can be helpful to both the family and the service coordinator to assist in securing those services, including those through public or private sources. These services must correspond to family identified outcomes.

<b>Service</b>	<b>Outcome #</b>	<b>Start Date Mo/Day/Yr</b>	<b>Duration (Months)</b>	<b>Provider Information</b>	<b>Fund Code</b>

**Review of the outcome/goal#** \_\_\_\_\_ must be conducted at least every six months **OR** more frequently if the family requests a review to determine the degree of progress toward achieving outcomes and whether modification or revision of the outcomes or services is necessary. The team will use the following scale to evaluate progress:  
 1 – Situation changes, outcome not needed 2 – Situation unchanged, still need outcome 3 – Outcome partially attained  
 4 – Outcome accomplished

**Review Date:**

<b>Progress Summary</b>	Team Eval	<b>Modifications/Revisions</b>

I participated in the review of this outcome.

Parents Initials



**Transition Planning**

The IFSP must include the steps to be taken to support the transition of the child into, within and from the Early On early intervention system. This section may be completed during a periodic review or evaluation of the IFSP, or at other times as appropriate. Transition activities include discussions with, and training of, parents regarding future placements, procedures to prepare the child, family and service providers for these changes. With parent consent, information about the child is shared with receiving providers to ensure continuity of services and assist in planning. **Transition needs should be expanded in an outcome within the IFSP to provide more specific details.**

What activity is needed?	Date Initiated	Who is Responsible?	Date Completed
<b><i>Begin discussing transition process with family</i></b>			
Review child's progress			
Identify current places and daily routine/activities			
Discuss options for child <ul style="list-style-type: none"> <li>• special education</li> <li>• Head Start</li> <li>• therapy/consultation-private providers</li> <li>• early childhood programs</li> <li>• everyday community learning activities</li> </ul>			
Visit possible settings/programs before a choice is made			
Decide on child's next setting/program			
Talk to child about transition			
Prepare a list of questions for the new staff			
Write down information about child that would be useful to the new staff			
<b><i>Send specified information to new staff with parent's informed written consent</i></b>			
Providers from new setting/program visit family			
Visit the new setting/program with child and meet the new staff			
<b><i>Sign form authorizing disposition of child's Early On® records</i></b>			
Attend meeting with staff from current and new settings/programs			
Child begins new setting/program			
Old staff maintains contact, as appropriate, with family after new activities begin			

Transition Date \_\_\_\_\_ Where transitioned to \_\_\_\_\_

## ***Method for Delivering Early Intervention Services\****

<b>Early Intervention Service Options</b>	<b><i>Location</i></b>	<b><i>Funding Code</i></b>
16 - Assistive Technology	31 – Home	A. WIC
01 - Audiological Services	33 – Program for Typical Children	B. ISS
02 - Family Training, Counseling, Home Visit	34 – Service Provider Location (Out Patient)	C. Special Education
03 - Health Services	35 – Program for Children w/ Delays/Disabilities	D. Early On
04 - Medical Diagnostic Services	36 – Hospital (In Patient)	E. Private Insurance
05- Nursing Services	37 – Residential Facility	F. Medicaid
06 - Nutrition Services	38 – Other Setting _____	G. FIA
07 - Occupational Therapy		H. The Family
08 - Physical Therapy		I. CSHCS
09 - Psychological Services		J. CMH
10 – Service Coordination		K. MI Child
13 - Special Instruction		L. Other _____
12 - Social Work		
14 - Speech/Language		
11 - Transportation		
17 - Vision Services		
15 – Other EI Services _____		

\*Early Intervention services must meet the developmental needs of the child and the needs of the family related to enhancing the child’s development, and are based upon the Outcomes developed. Services are selected in collaboration with the parents and provided by qualified personnel in conformity with the IFSP. **Families initial each service to which they agree.**

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