FLORIDA DEPARTMENT OF HEALTH, CHILDREN'S MEDICAL SERVICES, EARLY STEPS
INDIVIDUALIZED FAMILY SUPPORT PLAN (IFSP) and EVALUATION REPORT

Form A **Page of Form A**

Child's Name: Last First MI A.K.A:

DOB: Location of Birth: Child I.D. # Gender: ☐Male ☐Female (Check)

Child's Primary Language / Mode of Communication:

Check one: ☐PARENT ☐GUARDIAN ☐FOSTER PARENT ☐SURROGATE PARENT ☐ OTHER:

Name(s):

Address:

City: County: Zip Code:

Phone: Alternate Number: E-mail:

Best time to call: Primary Language used in home / Mode of Communication:

Check one: ☐PARENT ☐GUARDIAN ☐FOSTER PARENT ☐SURROGATE PARENT ☐ OTHER:
(Additional Caregiver as Appropriate)

Name(s):

Address:

City: County: Zip Code:

Phone: Alternate Number: E-mail:

Best time to call: Primary Language used in home / Mode of Communication:

Is an interpreter needed for the family? If so, what kind of interpreter?

Insurance / Resources: (check all that apply)

KidCare (Title XXI)
Medicaid: ☐Yes ☐ No ☐ Pending
CMS Network ☐Yes ☐ No ☐ Pending
MediKids ☐Yes ☐ No ☐ Pending
Florida Healthy Kids ☐Yes ☐ No ☐ Pending
SSI: ☐Yes ☐ No ☐ Pending
SafetyNet: ☐Yes ☐ No ☐ Pending

Private Insurance: ☐Yes ☐No Type: ☐ HMO ☐PPO
Company Name:
Primary Care Physician's Name:
Other Resource:

FAMILIES: The following people can help you with your questions and concerns.

Service Coordinator Name / Agency:
Phone: Fax:
Address: City Zip Code
Family Resource Specialist: Phone:

Current IFSP Date: Review IFSP Date:

Referral Date: Review IFSP Date:

Interim IFSP Date: Review IFSP Date:

Initial IFSP Date: Review IFSP Date:

6 month IFSP Date Due: Annual IFSP Date Due:

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IFSP Date: Name: DOB:

Family Information/Routines/Concerns/Priorities/Resources

Family: Who are the people living in your home? Please include full names and relationships. Include ages and gender of children.
Daily Routines: What are your child's and family's daily activities? Where does your child spend the day? With whom does your child regularly interact? (Include your child's activities, routines and favorite toys.) What activities, routines, and places are challenging to your child and family?
Family's Areas of Concern: What concerns do you have about your child's development and/or any other family challenges? Questions and concerns about your child may include issues such as feeding, sleeping, playing, communicating, behavior, health, transportation, food/shelter, etc.
Priorities: Which concerns above would you like to focus on first? What do you hope Early Steps can help you with?
Friends/Supports/Resources: When you need help, who do you call and how do they help you? What types of resources do you have to meet your family's needs? These may include family strengths, childcare, transportation and financial resources. List strengths you feel your family has to meet challenges.

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Form C

IFSP Date: Name:

DOB: Chronological Age: Adjusted Age:

Pre-Assessment Planning

Does the child have an Established Condition? YES ☐ NO ☐ Condition:

Collected information indicates possible Developmental Delay/Concern? YES ☐ NO ☐ In what developmental domains?

Fine motor	YES ☐	NO ☐	Communication	YES ☐	NO ☐
Gross motor	YES ☐	NO ☐	Adaptive-self-help skills	YES ☐	NO ☐
Social-emotional	YES ☐	NO ☐	Vision	YES ☐	NO ☐
Cognitive	YES ☐	NO ☐	Hearing	YES ☐	NO ☐

Screening was conducted to identify possible Developmental Delay/Concern? YES ☐ NO ☐ In what developmental domains?

Fine motor	YES ☐	NO ☐	Communication	YES ☐	NO ☐
Gross motor	YES ☐	NO ☐	Social-emotional	YES ☐	NO ☐
Cognitive	YES ☐	NO ☐	Adaptive-self-help skills	YES ☐	NO ☐

Screening Tool(s):

Screener(s):

Date(s) of Screening:

Health Status:	**Medications List:**
Medical Diagnosis:	**Nutritional Status:**
Immunizations Current: YES ☐ NO ☐	**Hospitalizations:**
Allergies:	**Other Comments:**

Recommendations for Evaluation and Assessment:

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Form D **Page of Form D**

IFSP Date: Name:

DOB: Chronological Age: Adjusted Age:

Date of Eligibility Evaluation (if performed): Date of Assessment:

Methods of Evaluation/Assessment: ☐ Test Instrument Administered ☐ Parent Report ☐ Professional Observation ☐ Collateral Information

List Tools Used:

Evaluation/Assessment Information

This page will address your child's current level of functioning in the following areas: fine/gross motor, social-emotional, cognitive, communication, adaptive-self-help, vision, hearing, and growth/nutrition status.

AREA	SUMMARY OF PRESENT STATUS: Include Dates of Evaluation/Assessment	Standard Deviation or % Delay

Evaluator: **Discipline:** **Signature:** **Date:**

Evaluator: **Discipline:** **Signature:** **Date:**

Evaluator: **Discipline:** **Signature:** **Date:**

Evaluator: **Discipline:** **Signature:** **Date:**

Evaluator: **Discipline:** **Signature:** **Date:**

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Form E **Page of Form E**

IFSP Date: Name:

DOB: Outcome #:

Outcome/Action To Take

OUTCOME- What would you like to see happen for your child/family?

STRATEGIES- Activities to be imbedded in daily routine of your child and family to achieve this outcome:

RESOURCES- People or resources that can help achieve this outcome:

PROGRESS- Timeline and criteria for determining progress/indicators of how the child's behavior/daily life in the family has improved:

Natural Environment Justification: Services/supports/strategies that have been used to try to achieve the outcome in Natural Environment?

How will the intervention be incorporated into daily routines and activities? Describe plans for ensuring that this outcome is addressed in the natural environment in the future (include a timeline).

Progress Towards the Outcome:

Date Reviewed: ☐ Outcome reached ☐ Continue outcome ☐ Outcome Modified

Modifications:

☐ I have received prior notice of the proposed new, changed or terminated services and understand the reason(s) for taking the action(s).
☐ I have received a copy and explanation of my procedural safeguards.

____________________________________(Parent/Guardian Signature) Date:

____________________________________(Signature) Role: Date:

____________________________________(Signature) Role: Date:

Date Reviewed: ☐ Outcome reached ☐ Continue outcome ☐ Outcome Modified
Modifications:

☐ I have received prior notice of the proposed new, changed or terminated services and understand the reason(s) for taking the action(s).
☐ I have received a copy and explanation of my procedural safeguards.

____________________________________(Parent/Guardian Signature) Date:

____________________________________(Signature) Role: Date:

____________________________________(Signature) Role: Date:

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Form F **Page of Form F**

IFSP Date: Name: DOB:

Summary of Services

Part C Eligibility Criteria

☐ Established Condition of:

☐ Developmental Delay in the area(s) of:

SUMMARY OF INFORMAL SUPPORTS TO PROMOTE THE ACHIEVEMENT OF OUTCOMES:

EARLY STEPS SERVICES

Provider Information (Name/Agency)	Service Provider Role (primary service provider, consultant, etc)	Service	Location Code	Natural Environment Y / N	Payer of Service	Start Date End Date Authorization Period	Related to Outcome Number	Frequency/ Intensity

Location Codes: 1=Home 3=Hospital 4=School 5=Childcare Center 6=Other 7=Clinic 8=Residential Facility 9=Early Intervention Classroom A=Community Agency F=Family Daycare Home P=Public Place

OTHER SERVICES: These services may be helpful to your child and family, but are not covered under Part C. The identification of these will help the service coordinator and the IFSP Team to better assist you in coordinating all your services.

Outcome/Service	Activities/Steps Needed	Timeline	Provider Name/Agency Responsibility	Funding Source

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IFSP Date: Name: DOB:

Transition Plan

Transition Planning Meeting date:

Reason for Transition Plan:

Concerns of the family regarding Transition:

Potential Program/Placement/Other Options Discussed: (Healthy Start, Another Local Early Steps, Developmental Disabilities Program, Head Start, Early Head Start, School Readiness Program, School District, Private Preschool or other community agency)

What events must occur to help this transition occur?

Identify steps to help the child and family prepare for new settings	Responsible Person/Agency	Funding Resources	Target Date	Date Completed

Signature of Parent/Guardian

Service Coordinator

IFSP Team Member

Signature of Parent/Guardian

IFSP Team Member

Local School District Representative

Signature of Community Representative

Signature of Other Community Representative

Miscellaneous Other

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Form H **Page of Form H**

IFSP Date: Name: DOB:

YOUR INDIVIDUALIZED FAMILY SUPPORT PLAN TEAM: The Team of people working with your family.

Printed Name	Position/ Role	Address	Telephone	IFSP Participants (Initial)	May receive Copy of IFSP (Family Initial)
	Parent/ Guardian				
	Parent/ Guardian				
	Service Coordinat or				
	Primary Service Provider				
	Primary Care Physician				

I received the following: ☐ Copy of service provider options list ☐ Explanation of procedure for requesting new Service Coordinator ☐ Copy of Procedural Safeguards ☐ Copy of Family Resource Specialist contact information ☐Copy of Early Steps brochure w/Central Directory phone number ☐Explanation of Early Steps Complaint Procedures ☐ Copy of Individualized Family Support Plan

Parent/Guardian Comments or Concerns:
I understand that signing the IFSP constitutes consent to begin services except as noted below.

Comments/concerns I wish to add:

I helped write this plan, agree with it, and agree for services to be provided. I have received prior notice of any proposed new, changed or terminated services and understand the reason(s) for taking the action(s). I have been told what to do if I disagree with this plan. I have been given a copy of the procedural safeguards for Part C or Part B of IDEA, as appropriate, and these rights and safeguards have been explained. I give permission for copies of this plan to be released to the individuals(s) noted above as indicated by my initials beside each name.

Parent/Guardian Signature Date

Signature Relationship Date

Signature	Relationship	Date