Reset Form

INDIANA'S INDIVIDUALIZED FAMILY SERVICE PLAN TO ENHANCE THE CAPACITY OF FAMILIES TO MEET THE SPECIAL NEEDS OF THEIR CHILD

State Form 46514 (R15 / 7-15)

First Steps

IFSP		
Initial date (*month, day, year*)	Annual effective date (*month, day, year*)	County

SECTION 1: IDENTIFYING INFORMATION

Name of child (*last, first, middle initial*) *		A.K.A. name	
Social Security number **	Date of birth (*month, day, year*) *	Chronological / adjusted age *	Gender *
First Steps identification number *			
Family's primary language / mode of communication			
Child's primary language / mode of communication *			

Type of representative (*check one*): *

☐ Parent ☐ Guardian ☐ Foster parent ☐ Surrogate parent

Name of representative(s) *		
Address (*number and street*) *		
City * , IN	ZIP code *	County *
Work telephone number * ( )	Home telephone number * ( )	
Cellular telephone number * ( )	E-mail address	

OTHER CONTACT INFORMATION

Name(s) of other contacts		
Address (*number and street*)		
City , IN	ZIP code	County
Work telephone number * ( )	Home telephone number * ( )	
Cellular telephone number * ( )	E-mail address	

SECTION 2: SERVICE COORDINATION INFORMATION

Name of service coordinator *	Name of agency *	
Telephone number(s) * ( )	Fax number * ( )	
Address (*number and street*) *		E-mail address
City * , IN	ZIP code *	
Name of intake coordinator	Telephone number ( )	
Fax number ( )	E-mail address	
Address (*number and street*)		
City * , IN	ZIP code *	

* Denotes part of the electronic record.

** Your child's Social Security number is requested in order to expedite processing this IFSP. Disclosure is voluntary and you will not be penalized for refusal per I.C. 4-1-8-1.

Name of child	Date of birth (*month, day, year*)	IFSP date (*month, day, year*)

SECTION 3: SUMMARY OF CHILD'S PRESENT LEVEL OF PERFORMANCE & EVALUATION INFORMATION

Please document the requested information below. All information should relate to the developmental needs of the child and family and should be gathered from discussion with the family.

List child / family strengths:

Concerns / needs related to the child's development:	Medical diagnosis / health status:
Screening results: **Vision:** ☐ Passed ☐ Concerns Comments:	Screening results: **Hearing:** ☐ Passed ☐ Concerns Comments:

Please document information relating to the child's development. Information may be gleaned from assessments, structured observation or other methods. **Parent report must be utilized.** The statement about the child's present level of performance must be based on professionally acceptable objective criteria. This information is then to be utilized in the determination of eligibility.

DOMAIN (*Person / Date*)	**ASSESSMENT PROCEDURES** *Please check all procedures used.*	**STATEMENT OF CHILD'S CURRENT LEVEL OF PERFORMANCE** ☐ Child in NICU *Describe the child's current level of performance. In addition, provide Raw score and Standard Deviation. Check if services are recommended.*	
Physical ** Development Date (*mo., day., yr.*)	☐ Structured observation ☐ State approved assess.* ☐ Other assessment ☐ Parent report (*required*)	Fine Motor: Raw Score _____ Deviation _____ Services recommended: ☐ Yes ☐ No	Gross Motor: Raw Score _____ Deviation _____ Evaluation recommended: ☐ Yes ☐ No
Adaptive Date (*mo., day., yr.*)	☐ Structured observation ☐ State approved assess.* ☐ Other assessment ☐ Parent report (*required*)	Raw Score _____ Services recommended: ☐ Yes ☐ No	Deviation _____ Evaluation recommended: ☐ Yes ☐ No
Cognitive Date (*mo., day., yr.*)	☐ Structured observation ☐ State approved assess.* ☐ Other assessment ☐ Parent report (*required*)	Raw Score _____ Services recommended: ☐ Yes ☐ No	Deviation _____ Evaluation recommended: ☐ Yes ☐ No
Communication Date (*mo., day., yr.*)	☐ Structured observation ☐ State approved assess.* ☐ Other assessment ☐ Parent report (*required*)	Raw Score _____ Services recommended: ☐ Yes ☐ No	Deviation _____ Evaluation recommended: ☐ Yes ☐ No
Social Date (*mo., day., yr.*)	☐ Structured observation ☐ State approved assess.* ☐ Other assessment ☐ Parent report (*required*)	Raw Score _____ Services recommended: ☐ Yes ☐ No	Deviation _____ Evaluation recommended: ☐ Yes ☐ No

* State approved assessment: Assessment, Evaluation, and Programming System for Infants and Children (AEPS) Second Edition.
** Physical Development is defined as motor skills, vision and hearing.

Name of child	Date of birth (*month, day, year*)	IFSP date (*month, day, year*)

SECTION 4: OUTCOMES

This page should be duplicated, as needed, one outcome per page	Outcome number

The IFSP must include the major outcomes expected to be achieved for the child and family, and the criteria, procedures and timelines used to determine the achievement of the outcome. Outcomes should be written in a language that is easily understood by the family and all IFSP Team members. The outcome should not include specific services or individual names until the IFSP is completed. All outcomes must be reviewed and discussed with the family. At that time, circle the type of service or discipline that is mutually selected to be the most appropriate to assist the family in addressing each strategy or activity.

Outcome Statement: What we would like to see happen for our child / family:	So that:

THINGS WE HOPE TO SEE TO KNOW WE ARE MAKING PROGRESS:	BY WHEN?

STRATEGIES FOR WORKING ON THIS OUTCOME UTILIZING THE DAILY ROUTINES AND ACTIVITIES OF OUR CHILD AND FAMILY:	BRAINSTORM PEOPLE WHO/RESOURCES THAT CAN HELP. CIRCLE THE FINAL SELECTION

Date (*month, day, year*) (*if an addendum page*)

Name of child	Date of birth (*month, day, year*)	IFSP date (*month, day, year*)

SECTION 5: SERVICE COORDINATION WORKSHEET / OUTCOME

Service Coordinator role: To provide service coordination services that assist and enable an infant or toddler and the child's family to receive the services, rights and procedural safeguards authorized to be provided under the early intervention program. Service coordination involves assisting parents in gaining access to early intervention services, coordinating the provision of early intervention services and other services the child needs, facilitating parent to parent support services, facilitating the timely delivery of available services, and continuously seeking the appropriate services and situation necessary to benefit the development of the child for the duration of the child's eligibility.

RESPONSIBILITIES:

ASSESSMENT OF CLIENT NEEDS:

☐ Complete family interview / exit summary	Date (*month, day, year*)
☐ Arrange for additional evaluations, assessments, health screenings, etc. _____	Date (*month, day, year*)
☐ Other activities: _____	Date (*month, day, year*)

COORDINATION / ADVOCACY:

☐ Assist family in locating community resources/parent supports: _____	Date (*month, day, year*)
☐ Coordinate services/communications with other service providers: _____	Date (*month, day, year*)
☐ Coordinate services/communications with primary medical provider: _____	Date (*month, day, year*)
☐ Facilitate referrals to other programs (*i.e., Medicaid Waiver, SSI, etc.*)_____	Date (*month, day, year*)

MONITORING OF IFSP:

☐ Contact family/providers regarding progress toward outcomes as written in IFSP as follows:

Preferred method of contact (*i.e., face-face, e-mail, phone, etc.*)_____

Preferred frequency of contact: (*i.e., monthly, quarterly, etc.*)_____

☐ Receive and disseminate quarterly progress reports: _____

☐ Coordinate and plan for 6 month review of IFSP by: _____	Date (*month, day, year*)

☐ Facilitate recommended changes to IFSP, including AT requests _____

☐ Maintain/review EI file at SPOE: _____

EVALUATION OF IFSP

☐ Additional evaluations needed to determine annual eligibility: _____

☐ Meet with family to discuss family concerns, priorities, and resources prior to annual IFSP: _____

☐ Coordinate and plan for annual IFSP by: _____

☐ Complete Family Update form, including cost participation activities: _____

FINANCIAL CASE MANAGEMENT

☐ Review and update Private Medical Health Insurance form: _____

☐ Follow-up or complete CSHCS/Hoosier Healthwise application: _____

Name of child	Date of birth (*month, day, year*)	IFSP date (*month, day, year*)

SECTION 6: TRANSITION CHECKLIST / OUTCOME

Duplicate as needed.	Outcome number

The IFSP must include the steps to be taken to support the transition of the child into, within and from the First Steps early intervention system. This section may be completed during a routine review or evaluation of the IFSP, or at other times as appropriate. This includes activities designed to ensure a smooth transition from the hospital to home, the selection of service providers, transition between center-based services to home, the addition or reduction of services, or the transition to services at age 3 OR when the child is no longer eligible. 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 parental 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 a specific Outcome within the IFSP and will provide more specificity/detail.

PROJECTED DATE(S):	**Transition activities into the First Steps program:**	PROJECTED DATE(S):	**Transition activities out of the First Steps program:**
	● Transition from hospital, neonatal intensive care unit to home, and into early intervention services to ensure that no disruption occurs in necessary services. **Transition activities within the First Steps program:** ● Family changes that may affect IFSP service delivery *(i.e., employment, birth or adoption of sibling, medical needs of other family members)* ● Child changes that may affect IFSP service delivery (*i.e., hospitalization or surgery, placement in a child care program, addition of new equipment or technology, medication changes*) ● Introduction of new or a change in Service Provider(s) ● Termination of existing IFSP services ● Other: _____		Exiting the First Steps system: ● Contact CSHCS Customer Service/Prior Authorization Unit (*if applicable*) to explore future service options. ● Explore community program options for our child ● Explore community program options for our family ● Discuss transition process and our rights and responsibilities under Part C ● Send basic demographic information to the local education agency at thirty (30) months of age ● Send specific information, including a copy of the most recent evaluation and assessments and most recent IFSP, to the local education agency, with our informed, written consent, at our thirty (30) months of age ● Send specific information to community programs, upon our informed, written consent, to facilitate service delivery or transition from the First Steps early intervention system ● Convene the transition meeting ● Other: _____

Outcome: (*related to transition)*

STRATEGIES FOR WORKING TOWARD TRANSITION	WHO IS RESPONSIBLE?	TIMELINE / EXPECTED DATE OF COMPLETION

Name of child	Date of birth (*month, day, year*)	IFSP date (*month, day, year*)

SECTION 7: NATURAL SETTINGS / ENVIRONMENTS

Federal statute requires that early intervention services be provided in natural environments and may only be provided in other settings when services cannot be achieved satisfactorily in the natural environment. Please complete the following section. If the Family Interview form has been completed within the past thirty (30) days, it is not necessary to complete this section of the IFSP, as the Family Interview information may be utilized.

Please check the following people that are involved in your child's care and check those you would like included in your child's services:

	Please involve
☐ Mother	☐
☐ Father	☐
☐ Step parents	☐
☐ Foster parents	☐
☐ Grandparents	☐
☐ Other caregiver	☐
☐ Childcare provider	☐

My child is able to complete the following routines successfully and independently:

	YES	WITH HELP	I WOULD LIKE FS TO HELP
● Get up in the morning	☐	☐	☐
● Dressing	☐	☐	☐
● Meal time	☐	☐	☐
● Inside play	☐	☐	☐
● Outside play	☐	☐	☐
● Getting along with peers	☐	☐	☐
● Family games	☐	☐	☐
● Nap time	☐	☐	☐
● Toileting time	☐	☐	☐
● Going to bed	☐	☐	☐
● Leaving home	☐	☐	☐
● Other:	☐	☐	☐

In the past two (2) weeks my child has participated in the following community settings: Please note if there have been any concerns with access to these settings.

- ☐ Grocery shopping
- ☐ Other shopping
- ☐ Visiting friends / relatives
- ☐ Going out to eat
- ☐ Attending social activities
- ☐ Attending a religious service
- ☐ Childcare
- ☐ Head start
- ☐ Community children's activities
- ☐ Community event
- ☐ Other: _____

Once services are written into the IFSP, **this section must be completed for any service that will not be provided in the child's Natural Environment**. Discussion must include why the service will be more appropriately provided in this setting, what barriers exist for the provision of service in the natural environment and how the services will be generalized for incorporation into daily routines and activities. For clarification purposes, "setting" refers to the physical place where services will be provided and "environment" refers to the approach to be used in providing services, which may include parent-directed services, individual child-focused services, or services provided within a group.

1. What barriers prohibit the provision of services in the child/family(s) daily routines and activities?

2. How will this barrier be addressed in the chosen location of service?

3. What will need to change in order for this service to be provided within the family's routine?

4. How will this need be accomplished / addressed by the team?

Name of child	Date of birth (*month, day, year*)	IFSP date (*month, day, year*)

SECTION 8: EARLY INTERVENTION SERVICES

This page is part of the electronic record. Early intervention services must meet the developmental needs of the child and family and are based upon the Outcomes developed. Services are selected in collaboration with the parents and provided under public supervision by qualified personnel in conformity with the IFSP. Unless otherwise indicated, the early intervention services listed below are processed through the Central Reimbursement Office. Any service that is to be provided in a setting other than the natural environment of the child must be documented in Section 7 of the IFSP.

EARLY INTERVENTION SERVICES OPTIONS			LOCATION
Assistive technology	Nursing services	Social work services	1. Program designed for children w/ delays/disabilities
Audiological services	Nutrition services	Special instruction	2. Program designed for typically developing children
Health services	Occupational therapy	Speech/language therapy	3. Home
Medical diagnostic services	Physical therapy	Transportation	4. Hospital (*inpatient*)
	Psychological services	Vision services	5. Residential facility
			6. Service provider location
			7. Other setting

SERVICES	RELATED OUTCOME	FREQUENCY AND INTENSITY OF SERVICE	START DATE	END DATE	LOCATION CODE	✓ IF ON-SITE	PROVIDERS INFORMATION NAME AND AGENCY
Service Coordination	ALL	Ongoing				☐	
						☐	
						☐	
						☐	
						☐	

The contents of this completed IFSP have been fully explained to me. I give informed, written consent to implement the services described in this section of the IFSP confirmed by my signature on this form. I also acknowledge the following:

I understand that this form serves as my ten (10) day written notice of the actions being proposed / refused and have been given an explanation of why the action is being proposed / refused. I have received a copy of parent's rights and complaint procedures (under section 470 IAC 3.1-14-1) for the First Steps Early Intervention System and had these rights explained verbally by my Service Coordinator. The notice was written in language understandable to me and in my native language, or translated orally or by other means to my native language or other mode of communication. I understand that I may refuse any proposed service(s) / action(s) and my Service Coordinator will document my refusal.

I am responsible to meet all First Steps financial obligations and I am aware that if payments are sixty (60) days or greater past due, copay eligible services will be suspended until payment is received to bring my First Steps account current. If I would like further consideration of my income, I may provide documentation of income or family medical expenditures to my Service Coordinator, who will review the income and deductions within thirty (30) days of my request. If income verification is not provided, I will be billed the maximum allowable monthly co-payment fee.

☐ I consent to First Steps accessing my insurance.

☐ I am NOT providing consent to access my insurance. I understand that First Steps will not retroactively bill my insurance at a later date.

☐ Not applicable due to lack of insurance.

Signature of parent / guardian / surrogate parent	Date (*month, day, year*)	Signature of parent / guardian / surrogate parent	Date (*month, day, year*)

SECTION 9: OTHER SERVICES

To the extent appropriate, the IFSP must include services that are **not required or covered** under Part C. Please check the other resources utilized by the family.

- ☐ No other services
- ☐ Head Start / Early Head Start
- ☐ Healthy Families
- ☐ TANF
- ☐ WIC
- ☐ Child care
- ☐ Indiana Deaf / Blind Project
- ☐ Family Preservation
- ☐ Waiver
- ☐ Respite
- ☐ Cochlear implant
- ☐ Psychosocial
- ☐ Indiana School for the Deaf
- ☐ Indiana School for the Blind
- ☐ Other
- ☐ Outreach for Deaf / Hard of Hearing
- ☐ Preschool
- ☐ Hoosier Healthwise
- ☐ CSHCS
- ☐ Specialized Medical Services
- ☐ Supplemental Nutrition Assistance Program (SNAP)

BASED ON THE ATTACHED SUMMARY OF THE CHILD'S PRESENT LEVEL OF PERFORMANCE AND EVALUATION INFORMATION, I AGREE THAT THE RECOMMENDED THERAPIES ARE NECESSARY AND APPROPRIATE AND MAY BE PROVIDED AS LISTED FOR UP TO ONE YEAR FROM THIS DATE.

Printed name of physician	Telephone number	Fax number
	( )	( )
Signature of physician		Date (*month, day, year*)

Please return the signed copy of this page to the child's Intake / Service Coordinator, _____.

Telephone number	Fax number
( )	( )

If you have additional questions relating to the evaluation information for this child, you may contact the Assessment Team (AT):

Name of contact	Telephone number	Fax number
	( )	( )

Name of child	Date of birth (*month, day, year*)	IFSP date (*month, day, year*)

SECTION 10: IFSP DEVELOPMENT TEAM AND CONTRIBUTORS

IFSP meetings **must include** the parent(s), other family members as requested by the parent, an advocate or person outside the family as requested by the parent, the Service Coordinator, person(s) directly involved in conducting the evaluations and assessments, and as appropriate, persons who will be providing services to the child or family.

PRINTED NAME	ROLE	TELEPHONE	SIGNATURE	TIME IN	TIME OUT	AUTH. TIME
	Parent *					
	Parent *					
	Intake Coord.					
	Service Coord.					
	AT Team member					
	AT Team member					

A copy of this IFSP will be sent to the individuals listed above, the providers listed in section 8, as well as those persons indicated below.

Name of person	Name of person

IFSP MEETING MINUTES

Written documentation of the IFSP meeting must be recorded. Notes should document general discussion, any unresolved issues, and follow-up activities. (*Attach additional pages as needed*)

Signature of notetaker	Location of meeting	Today's date (*month, day, year*)

NOTES: