Reset Form

CHANGES TO THE IFSP

State Form 51841 (R7 / 08-26)
FAMILY AND SOCIAL SERVICES
DIVISION OF DISABILITY AGING AND REHABLITATIVE SERVICES

first steps

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

JUSTIFICATION / REASON FOR ACTION

Decrease in services due to:
- ☐ Outcome achieved
- ☐ Progress being made toward outcome
- ☐ Cost participation
- ☐ Other parent reason / preference: _____

Increase in services:
Please attach the Documentation of Team Discussion form. For new services, please attach a new Outcome page. For all increases, include a narrative explanation from the team describing the intent and rationale for the service increase.

ACTION PROPOSED / MODIFICATIONS: ***The Team is recommending the following modifications, as listed below.***

Use (+) to add (-) to terminate	Modification in service(s)	Related to outcome number	Frequency / Intensity (*times per week or month / minutes per time*)	Anticipated Start Date (*month, day, year*)	End Date (*month, day, year*)	✓ if on-site	Location Code	Provider Information (*include name of provider and payee*)
						☐		
						☐		
						☐		
						☐		

I understand 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. This notice was written in language understandable to me and in my native language, or translated orally or by other means to my native language. I participated in the IFSP review process and agree with the revisions reflected in this section. I give informed, written consent to implement the services described in this document confirmed by my signature on this form. A copy of this completed modification page will be distributed to members of my IFSP team once all signature have been obtained. 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, copayment 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 copayment 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 / foster parent / surrogate parent (*required*)	Date (*month, day, year*)	
Signature of parent (*other*)	Date (*month, day, year*)	
Signature of service coordinator (*required*)	Date (*month, day, year*)	
Address of service coordinator (*number and street, city, state, and ZIP code*)	Telephone number ( )	Fax number ( )
Printed or typed name of physician	Telephone number ( )	Fax number ( )

Listed below are the services that the child is expected to receive once the modifications are approved:

Related outcome	Service	Intensity / frequency	Anticipated Start Date (*month, day, year*)	End Date (*month, day, year*)	On-site (✓)	Provider Name and Agency
					☐	
					☐	
					☐	
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					☐	

Once you have reviewed the above modifications to the IFSP, please indicate your agreement with the services planned for this child and family in the space provided. Please return this signed form to the Service Coordinator listed above and retain a copy with the IFSP document in your patient records. If for any reason you do not agree with the services set forth in the IFSP, please contact the Service Coordinator immediately to discuss your concerns. You may also attach comments to this form. By signing below, you agree with the recommended services being provided for up to one year from this date.

Signature of physician	Date (*month, day, year*)