County Birth to 3 Services

Individualized Family Service Plan

CHILD:
BIRTHDATE:

Service Coordinator:
Phone Number: Bayfield County 715-373-6144 ext. 138

Referral Date:

Initial IFSP Date: IFSP Review Due:

IFSP Review Date(s)*: 1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

7) _____ 8) _____ 9) _____

HFS 90.10(7); HFS 90.10(5)(e)
Revised: 03/10

ALL ABOUT Date:

Child lives with: Relationship: Parents	Other parent/guardian name: (if applicable)
	Address:
Home phone:	Home phone:
Alternate phone:	Alternate phone:
Email:	
Other parent/guardian: (if different from above) Address: Phone:	
Primary Language of Parents: English	Primary Language of Child: English
Spends day with: ☐ Mom ☐ Childcare Provider: _____ ☐ Dad ☐ Other (Specify): _____	
Siblings: none	
Other important people or information:	
Primary Medical Care Provider/Medical Home:	

Services and programs my child/family currently use:

☐ Badger Care Plus Standard Plan ☐ Health Dept. ☐ Honoring Our Children
☐ Healthy Start ☐ Support Groups ☐ ABC Family Resource Cntr
☐ Dept. of Human Services ☐ Katie Beckett ☐ W2
☐ WAKO ☐ Library ☐ WIC
☐ Family Support Program ☐ Medical Assistance ☐ Early Head Start
☐ Other

We want more information about the following programs:

_____

_____

TELL US ABOUT YOUR FAMILY

What is going well for your child and family right now? (e.g., activities, routines, times of day, relationships)	What is your family concerned or interested in learning more about?
People or supports that are helpful to your family:	What are some activities you enjoy doing with your child and family?
What would you like to see happen for your child and family in the next six months?	What activities or times of day are difficult or stressful for your child and family?

*HFS 90.09 (2)

SUMMARY OF ALL DEVELOPMENTAL AREAS*

(For use with the Early Intervention Team Report and IFSP. Include tools, strategies, and locations.)

Name: Date:
Birth date:
Age at evaluation: Adjusted Age:
Evaluation tools used:
Location of Evaluation:
Strategies:

PHYSICAL DEVELOPMENT

HEALTH (Includes Medical, Dental, Nutrition):

VISION/HEARING (Screening, Glasses, Hearing Aids, History of Ear Infections):

FINE MOTOR (Use of Hands and Upper Body, Sensory):

Developmental age:

GROSS MOTOR (Quality and Function of Movement, Equipment/Devices):

Developmental age:

* HFS 90.08(7)(h); HFS 90.08(7)(c); HFS 90.08(7)(h)(1); HFS 90.10(5)(a)

SUMMARY OF ALL DEVELOPMENTAL AREAS*

(For use with the Early Intervention Team Report and IFSP)

COMMUNICATION (Understanding, Expression, Intelligibility, Use of Language)
Developmental age:
COGNITION (Thinking, Play Skills, Sensory)
Developmental age:
SOCIAL EMOTIONAL (Engagement, Response to Caregivers, Coping, Sensory)
Developmental age:
SELF-HELP (Feeding, Dressing, Toileting, Sleeping)
Developmental age:

* HFS 90.08(7)(h); HFS 90.08(7)(c); HFS 90.08(7)(h)(1); HFS 90.10(5)(a)

EARLY INTERVENTION TEAM REPORT*

WISCONSIN EARLY INTERVENTION ELIGIBILITY DETERMINATION

Child's Name: _____ **Date:** _____

(Check A or B)

☐ A **This child meets the eligibility criteria for early intervention services (Check 1 or 2)*:**

☐ **1 a)** A developmental delay of 25% or greater or -1.3 standard deviation in the following area(s):

_____

b) Atypical development based on:

_____

☐ **2** A diagnosed physical or mental condition exists which has a high probability of resulting in a developmental delay. Specify condition(s) and source of diagnosis: _____

Comments:

_____

_____

☐ **B This child does not meet eligibility criteria for Birth to 3 services**:

Offer to re-screen the child within 6 months.

Notes: _____

The following community resources might benefit the family:

_____

The following information was given to the family:

_____

PARTICIPANTS IN EARLY INTERVENTION TEAM MEETING

Signature	***Title***
	Parent/Guardian
	Parent/Guardian
	Service Coordinator

* HFS 90.08(5); HFS 90.08(6); HFS 90.08(7); HFS 90.08(4)

CHILD AND FAMILY OUTCOME* Date:

We want: (What will happen or change?)
So that: (Why is this important?)
What is already happening? (What is the child doing now? What has been tried? What is working?)
We will know we are successful when: (What can we measure?)

What will happen within the child and family's everyday routines and activities and places?	Notes

Date(s) Reviewed: _____

Describe progress toward outcome:

Check one: ☐ Accomplished ☐ Continue ☐ Other: _____

* HFS 90.10(5)(c)

EARLY INTERVENTION SERVICES TO HELP 'S DEVELOPMENT

BIRTH TO 3 SERVICES Date:					
Services	**Start/End Dates**	**Location**	**Frequency***	**Intensity**	**Funding Sources**
Service Coordination			As needed	As needed	

Birth to Three providers are available to provide services 12 months of the year. Due to holidays and staff vacation, Birth to Three services will not be provided during the week of New Years, Memorial Day, Fourth of July, Christmas or Hanukah. If a service will not be provided in a natural environment, please attach a plan with steps to be taken to get back to a natural environment.

NEEDED MEDICAL AND OTHER SERVICES

(These are resources, supports or services that assist the family but are not funded by Birth to 3.)

SUPPORTS NEEDED	WHO WILL HELP	STEPS TAKEN	FUNDING SOURCE

X☐ IFSP Team discussion found that no medical or other services were identified at this time.

Comments:

_____

_____

* HFS 90.10(5)(d)

TEAM SIGNATURE PAGE*

► I/We have received a copy of and understand the parent and child rights.

► This plan reflects the outcomes that are important to my child and family.

► I/We give consent for the services described in this IFSP for my child and family.

► I understand that this plan will be shared with all team members listed below so we can work in partnership on behalf of my family.

Parent/Guardian Signature Date

Parent/Guardian Signature Date

Parent/Guardian Signature Date Reviewed

We have worked together with the family to create this Individualized Family Service Plan and agree that this plan will guide our work.

OTHER IFSP TEAM MEMBERS NAMES & SIGNATURES	Date
Service Coordinator:	
Team Member:	
Team Member:	
Team Member:	
Team Member:	
Team Member:	

* HFS90.12(2)(b)

TRANSITION PLAN FOR _____ Date:

A transition is any major event that impacts a child and family, such as moving out of county or state, moving into or between programs, coming home from the NICU, changing a child care situation, or turning 3.* For children turning 3, this page is to be filled out by 2 years 3 months.

What kind of transition is this?

What does your family want and hope for your child for this transition?

_____

_____

_____

Date(s) of transition planning discussions:

Who participated in these discussions and what options were discussed?

_____

_____

_____

_____

_____

_____

NEXT STEPS

Who will do what?	When?

If referring to public school system:

☐ Family given "Step Ahead at Age 3".

☐Non-identifying, confidential information forwarded to school district. Date: _____

☐Transition Planning Conference held and Preschool Options discussed. Date: _____

Comments: _____

☐Referral made at least 90 days before 3rd birthday. Date: _____

Comments: _____

* HFS 90.10(5)(f)

JUSTIFICATION FOR SERVICES PROVIDED IN LOCATIONS OTHER THAN NATURAL ENVIRONMENTS*

Child's Name: _____ Date: _____

List services and activities provided in a setting other than the child's natural environment:

Team recommendation, explaining why this outcome cannot be met in the child's natural environment:

How will the outcome be met in this setting?

What activities will be provided to include this outcome in the child's home and community environment?

When will services be provided in the child's home and community environment (time frame)?

* HFS 90.11(5)(a)