|  |  |  |
| --- | --- | --- |
| **DEPARTMENT OF HEALTH SERVICES**Division of Medicaid ServicesF-00989 (02/2017) |  | **STATE OF WISCONSIN** |
| **INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP)** |
| Click here to enter text. County Birth to 3 Program |
| Child’s Name | Date of Birth |
| Enter date | Enter date |
| Service Coordinator Name | Service Coordinator Phone Number |
| Enter date | enter date |
| Referral Date |
| Enter date |
| Early Intervention (EI) Team / IFSP Due Date |
| Click here to enter text. |
| Initial IFSP Date |
| Enter date |
| Annual IFSP Review Date Due |
| Enter date |
| IFSP Review Date(s) |
| 1. | Enter date |  |
| 2. | Enter date |  |
| 3. | Enter date |  |
| 4. | Enter date |  |
| 5. | Enter date |  |
| 6. | Enter date |  |
| 7. | Enter date |  |
| 8. | Enter date |  |
| 9. | Enter date |  |