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| **DEPARTMENT OF HEALTH SERVICES**  Division of Medicaid Services  F-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 |  | | | |