|  |  |  |
| --- | --- | --- |
| **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 |  |
| **DEPARTMENT OF HEALTH SERVICES**Division of Medicaid ServicesF-00989A (02/2017) | **STATE OF WISCONSIN** |
| **CHILD AND FAMILY INFORMATION** |
| Child’s Name | Date of Report |
| Enter date | Enter date |
| Parent / Legal Guardian Name | Parent / Legal Guardian Name |
| Enter date | Enter date |
| Relationship to Child | Relationship to Child |
| Enter date | Enter date |
| Street | City | State | Zip Code | Street | City | State | Zip Code |
| enter date | enter date | WI | enter date | enter date | enter date | WI | enter date |
| Phone Number | Phone Number |
| Enter date | Enter date |
| Alternate Phone Number | Alternate Phone Number |
| Enter date | Enter date |
| Email Address | Email Address |
| Enter date | Enter date |
| Other Caregiver Name | Other Caregiver Phone Number | Street | City | State | Zip Code |
| Enter date | Enter date | enter date | enter date | WI | enter date |
| Primary Language of Parent / Legal Guardian | Primary Language of Child |
| Enter date | Enter date |
| Child’s Race | Child’s Ethnicity: Hispanic |
| Enter date | [ ]  Yes [ ]  No |
| Spends Day With Name | Relationship |
| Enter date | [ ]  Mom [ ]  Dad [ ]  Childcare Provider (Name) Enter date [ ]  Other (specify) Enter date |
| List Others in the Child’s Home (Include Pets) |
| Click here to enter text. |
| List Other Important People in the Child’s Life |
| Click here to enter text. |
| Referral Source Name / Title / Contact Information |
| Click here to enter text. |
| Primary Medical Care Provider Name / Medical Home |
| Click here to enter text. |
| Community Supports (Select Services and Programs Child / Family Use) |
| [ ]  BadgerCare Plus | [ ]  Health Department | [ ]  SSI |
| [ ]  CYSHCN | [ ]  Healthy Start | [ ]  W2 |
| [ ]  Department of Human Services | [ ]  Katie Beckett | [ ]  WIC |
| [ ]  Family Resource Center | [ ]  Library | [ ]  YMCA/YWCA |
| [ ]  Family Support | [ ]  Medicaid/MA | [ ]  Support Groups Enter date |
| [ ]  Head Start | [ ]  FACETS | [ ]  Other Enter date |
| **DEPARTMENT OF HEALTH SERVICES**Division of Medicaid ServicesF-00989B (02/2017) | **STATE OF WISCONSIN** |
| **S**UMMARY OF DEVELOPMENT**(For use with the Early Intervention Team Report, IFSP and Child Outcome Summary Data)** |
| Child’s Name | Child Outcomes (CO) Completed Dates |
| Enter date | Entrydate | Exitdate |
| Date of Birth | Age At Evaluation | Adjusted Age |
| Enter date | Enter date | Enter date |
|  |
| Entry CO Date |
| Enter date |
| Participants in Information Gathering (List by name and role, include family) |
| Enter date |
| Procedures used for obtaining information (Check all that apply) |
|[ ]  Medical Records |  |
|[ ]  Health/Developmental History |  |
|[ ]  Professional Observations |  |
|[ ]  Discussion with Parents/Others |  |
|[ ]  Ongoing Visits with Child/Family |  |
|[ ]  Research |  |
|[ ]  List Assessment Tools | Enter date |
|  |  |  |
| Information gathered in the following locations: |
| Click here to enter text. |
|  |
| Exit CO Date |
| Enter date |
| Participants in Information Gathering (List by name and role, include family) |
| Click here to enter text. |
| Procedures used for obtaining information (Check all that apply) |
|[ ]  Medical Records |  |
|[ ]  Health/Developmental History |  |
|[ ]  Professional Observations |  |
|[ ]  Discussion with Parents/Others |  |
|[ ]  Ongoing Visits with Child/Family |  |
|[ ]  Research |  |
|[ ]  List Assessment Tools | Enter date |
|[ ]  Received in IEP Team Meeting |  |
| Information gathered in the following locations: |
| Click here to enter text. |
| **Health** (Include only information appropriate and relevant to child’s development) |
| Date: |
| Click here to enter text. |
| **Vision / Hearing** (Screening, Glasses, Hearing Aids, History of Ear Infections): |
| Date: |
| Click here to enter text. |
| **DEPARTMENT OF HEALTH SERVICES**Division of Medicaid ServicesF-00989C (02/2017) | **STATE OF WISCONSIN** |
| **SUMMARY OF DEVELOPMENT****CHILD’S POSITIVE SOCIAL EMOTIONAL SKILLS****(Including Social Relationships)*** Relating with adults
* Relating with other children
* Following rules related to groups or interacting with others (if older than 18 months)
 |
| Child’s Name | Date of Report |
| Enter date | Enter date |
| **Areas of Development Include**:* **Cognitive Development** (thinking; learning; problem solving; playing with adults or peers; attending; imitating actions of peers)
* **Social Emotional** (regulating emotions; engaging with peers, siblings, parents and other adults; showing affection)
* **Communication** (expressing self through gestures, sounds or words to indicate needs; communicating with peers; imitating sounds and gestures)

**Adaptive Development/Self-Help** **(**adapting to changes in routine or setting; helping meet own needs during routines with family, such as requesting more food during meals, putting on coat after play date; avoiding common dangers)* **Motor Skills** (ability to move and manipulate objects during play; reacting to changes in environment; need for positioning so child can interact with family and peers)
 |
| Date: |
| Click here to enter text. |
| In addition to the comprehensive summary above, provide **evidence** to answer the following questions:* Does the child ever function in ways that would be considered age appropriate?
* Does the child use any immediate foundational skills upon which to build age-appropriate functioning across settings and situations?
* To what extent is the child using immediate foundational skills across settings and situations?
 |
| Evidence to Support Child Outcome Process: |
| 1. Click here to enter text.
 |
| 1. Click here to enter text.
 |
| 1. Click here to enter text.
 |
| 1. Click here to enter text.
 |
| Entry CO Rating# | enter date | Exit CO Rating# | enter date |  |
| Exit CO: Has the child shown any new skills or behaviors related to each outcome area since the previous rating? |
| [ ]  Yes [ ]  No |
| **DEPARTMENT OF HEALTH SERVICES**Division of Medicaid ServicesF-00989D (02/2017) | **STATE OF WISCONSIN** |
| **SUMMARY OF DEVELOPMENT****CHILD’S USE OF KNOWLEDGE & SKILLS****(Including Communication, Language and Early Literacy)*** Thinking, reasoning, remembering, & problem solving
* Understanding symbols
* Understanding the physical & social worlds
 |
| Child’s Name | Date of Report |
| Enter date | Enter date |
| **Areas of Development Include**:* **Cognitive Development** (thinking; learning; problem solving; playing with adults or peers; attending; imitating actions of peers)
* **Social Emotional** (regulating emotions; engaging with peers, siblings, parents and other adults; showing affection)
* **Communication** (expressing self through gestures, sounds or words to indicate needs; communicating with peers; imitating sounds and gestures)

**Adaptive Development/Self-Help** **(**adapting to changes in routine or setting; helping meet own needs during routines with family, such as requesting more food during meals, putting on coat after play date; avoiding common dangers)* **Motor Skills** (ability to move and manipulate objects during play; reacting to changes in environment; need for positioning so child can interact with family and peers)
 |
| Date: |
| Click here to enter text. |
| In addition to the comprehensive summary above, provide **evidence** to answer the following questions:* Does the child ever function in ways that would be considered age appropriate?
* Does the child use any immediate foundational skills upon which to build age-appropriate functioning across settings and situations?
* To what extent is the child using immediate foundational skills across settings and situations?
 |
| Evidence to Support Child Outcome Process: |
| 1. Click here to enter text.
 |
| 1. Click here to enter text.
 |
| 1. Click here to enter text.
 |
| 1. Click here to enter text.
 |
| Entry CO Rating# | enter date | Exit CO Rating# | enter date |  |
| Exit CO: Has the child shown any new skills or behaviors related to each outcome area since the previous rating? |
| [ ]  Yes [ ]  No |
| **DEPARTMENT OF HEALTH SERVICES**Division of Medicaid ServicesF-00989E (02/2017) | **STATE OF WISCONSIN** |
| **SUMMARY OF DEVELOPMENT****CHILD’S INDEPENDENCE AND ABILITY TO MEET OWN NEEDS:*** Taking care of basic needs (e.g., showing hunger, dressing, feeding, toileting)
* Contributing to own health and safety (e.g., following rules, assisting with handwashing, avoiding inedible objects)
* Getting from place to place (mobility) and using tools (e.g., forks, pencils, strings attached to objects)
 |
| Child’s Name | Date of Report |
| Enter date | Enter date |
| **Areas of Development Include**:* **Cognitive Development** (thinking; learning; problem solving; playing with adults or peers; attending; imitating actions of peers)
* **Social Emotional** (regulating emotions; engaging with peers, siblings, parents and other adults; showing affection)
* **Communication** (expressing self through gestures, sounds or words to indicate needs; communicating with peers; imitating sounds and gestures)

**Adaptive Development/Self-Help** **(**adapting to changes in routine or setting; helping meet own needs during routines with family, such as requesting more food during meals, putting on coat after play date; avoiding common dangers)* **Motor Skills** (ability to move and manipulate objects during play; reacting to changes in environment; need for positioning so child can interact with family and peers)
 |
| Date: |
| Click here to enter text. |
| In addition to the comprehensive summary above, provide **evidence** to answer the following questions:* Does the child ever function in ways that would be considered age appropriate?
* Does the child use any immediate foundational skills upon which to build age-appropriate functioning across settings and situations?
* To what extent is the child using immediate foundational skills across settings and situations?
 |
| Evidence to Support Child Outcome Process: |
| 1. Click here to enter text.
 |
| 1. Click here to enter text.
 |
| 1. Click here to enter text.
 |
| 1. Click here to enter text.
 |
| Entry CO Rating# | enter date | Exit CO Rating# | enter date |  |
| Exit CO: Has the child shown any new skills or behaviors related to each outcome area since the previous rating? |
| [ ]  Yes [ ]  No |
| **DEPARTMENT OF HEALTH SERVICES**Division of Medicaid ServicesF-00989F (02/2017) | **STATE OF WISCONSIN** |
| **EARLY INTERVENTION TEAM REPORT /****WISCONSIN EARLY INTERVENTION ELIGIBILITY DETERMINATION** |
| Child’s Name | Date of Report |
| Enter date | Click here to enter a date. |
| **WPN:** The following decision has been made regarding your child’s eligibility determination: |
|[ ]  This child meets the eligibility criteria for early intervention (Birth to 3 Program). |
|[ ]  This child does not meet eligibility criteria for early intervention (Birth to 3 Program) based upon (list parental/caregiver input, names of standardized tests, observations, review of records, etc.) and reasons (list what the information states): |
|  | Click here to enter text. |
| Other Decisions Considered |
|[ ]  Not applicable; other decisions not discussed. |
|[ ]  This child meets the eligibility criteria for early intervention (Birth to 3 Program). |
|[ ]  This child does not meet the eligibility criteria for early intervention (Birth to 3 Program). |
| This eligibility determination is being made based upon the following information (list parental/caregiver input, names of standardized tests, observations, review of records, etc.) and reasons (list what the information states): |
|[ ]  1. A developmental delay of 25 percent or greater or -1.3 standard deviation in the following area(s) and based upon:
 |
|  | Click here to enter text. |
|   |
|[ ]  1. A diagnosed physical or mental condition exists that has a high probability of resulting in a developmental delay.
 |
| Diagnosis: | Click here to enter text. |
| Related Conditions: | Click here to enter text. |
| The Early Intervention team reviewed the following documents identifying the diagnosis: |
|  | Click here to enter text. |
|   |
|[ ]  1. Atypical development based on:
 |
|  | Click here to enter text. |
|   |
| You have the right to agree with or refuse the eligibility determination. Accompanying this early intervention team report is a copy of the parent and child rights. This is a brief review of the rights. If you would like a complete copy of the parent and child rights, please contact the Service Coordinator. |
|   |
| If this child has met the eligibility criteria for early intervention, the next step is to develop an Individualized Family Service Plan (IFSP). |
|[ ]  This child meets the eligibility criteria for early intervention services, and the family has agreed to participate in the Birth to 3 Program. |
|[ ]  This child meets the eligibility criteria for early intervention services; however, the family declines participation in the Birth to 3 Program at this time. |
|   |
| If this child did not meet the eligibility criteria for early intervention, the following is being offered to the family. |
|[ ]  Rescreen the child within six months. Notes: |
| Click here to enter text. |
|[ ]  The following community resources might benefit the family: |
| Click here to enter text. |
|[ ]  The following information was given to the family: |
| Click here to enter text. |
| **PARTICIPANTS IN EARLY INTERVENTION TEAM MEETING****Date of Meeting:** Enter date |
| By signing below, I acknowledge that the Birth to 3 Program requested information from me to include in this early intervention (EI) report, and I provided the most up-to-date information about my child and participated in the discussions that resulted in this EI report. I further understand and acknowledge that I had the opportunity to review and request changes to the information in this EI report and that I have the right to dispute the decisions regarding my child’s eligibility for the Birth to 3 Program. I was also informed that disclosure of this report will not occur unless otherwise permitted by law. |
| **SIGNATURE** – Parent / Guardian | Date Signed | Print Name / TitleEnter date |
| **SIGNATURE** – Parent / Guardian | Date Signed | Print Name / TitleEnter date |
| **SIGNATURE** – County Coordinator | Date Signed | Print Name / TitleEnter date |
| **SIGNATURE** – Service Coordinator | Date Signed | Print Name / TitleEnter date |
| **SIGNATURE** – Other | Date Signed | Print Name / TitleEnter date |
| **SIGNATURE** – Other | Date Signed | Print Name / TitleEnter date |
| **SIGNATURE** – Other | Date Signed | Print Name / TitleEnter date |
| **SIGNATURE** – Other | Date Signed | Print Name / TitleEnter date |
| **DEPARTMENT OF HEALTH SERVICES**Division of Medicaid ServicesF-00989G (02/2017) | **STATE OF WISCONSIN** |
| **TELL US ABOUT YOUR FAMILY** |
| Child’s Name | Date of Report |
| Enter date | Enter date |
| Child / Family Assessment Procedure Used |
| Enter date |
| This page is a summary of the information you have shared with us about your family. The purpose of this information is to help develop a plan and intervention strategies that are meaningful to your family. |
| Natural Supports / Resources (people or supports that are helpful to your family) |
| Date: |
| Click here to enter text. |
| Routines / Activities (describe the child/family’s day) |
| Date: |
| Click here to enter text. |
| Priorities of the Family (activities your family would like to do) |
| Date: Click here to enter text. |
| **DEPARTMENT OF HEALTH SERVICES**Division of Medicaid ServicesF-00989H (02/2017) | **STATE OF WISCONSIN** |
| **CHILD / FAMILY OUTCOME** |
| Child’s Name | Date of Report |
| Enter date | Click here to enter a date. |
| This page indicates the outcome(s) for the child and family to be supported through the Birth to 3 Program’s services. The outcomes are based on:* The family’s priorities.
* All areas of development.
* Participation in everyday routines.
 |
|  |
| Date: Enter date |
| When thinking about your family routines, what would you like your child to have a chance to do? (measurable result) |
| Click here to enter text. |
| What is happening now? What is working well? What do you want to see changed? What have you tried? What are you expecting to see next? (current status) |
| Click here to enter text. |
| When do you see this outcome being accomplished (upcoming events, holiday)? When will the goal be achieved? (timeline) |
| Click here to enter text. |
| What shall we try? How are we going to get there? Where will we start? Where will our joint planning begin; what will visits look like? (strategies) |
| Click here to enter text. |
| How are we going to know we are on the right track? (criteria—how will progress be determined, standard rule or test on which a decision is based) |
| Click here to enter text. |
| How will we measure progress on this outcome? (procedures—who/how determine progress) |
| [ ]  Parent report | [ ]  Observations of the child |
| [ ]  Ongoing assessment | [ ]  Periodic reviews of Individualized Family Service Plan |
| [ ]  Other: Enter date |
| Progress / Modifications or Revisions Toward Outcome |
| Date: |
| Click here to enter text. |
| Select Only One |
| [ ]  Accomplished | [ ]  Continue | [ ]  No Longer Important |
| **DEPARTMENT OF HEALTH SERVICES**Division of Medicaid ServicesF-00989J (02/2017) | **STATE OF WISCONSIN** |
| **TRANSITION PLAN—** **TURNING 3 YEARS OLD** |
| Child’s Name | Date of Report |
| Enter date | Enter date |
| A transition is any major event that impacts a child and family, such as moving out of the county or state, moving into or between programs, coming home from the NICU, changing a child care situation, or turning 3 years old. The most common transition is leaving the Birth to 3 Program at age 3. |
| What kind of transition is this? |
|[ ]  Turning 3 years old |
| Participants in the Transition Discussion |
| Date: |
| Click here to enter text. |
| POTENTIAL ELIGIBILITY Written Prior Notice (WPN) |
| Your child is close to turning 3. We propose your child: |
|[ ]  is potentially eligible for Local Educational Agency (LEA) services. This decision means limited contact information about your child will be shared with the LEA |
|[ ]  is not potentially eligible for LEA services |
|   |
| Other decision considered: |
|[ ]  is potentially eligible for LEA services |
|[ ]  is not potentially eligible for LEA services |
|[ ]  not applicable: other decision not discussed |
|   |
| This decision is recommended based upon (information and reasons): |
| Click here to enter text. |
| You have the right to agree with or refuse the proposed decision. Accompanying this document is a copy of the Parent and Child Rights and the actions to take if you do not agree with the proposed action. These are a brief review of the rights. If you would like a complete copy of the Parent and Child Rights, please contact your service coordinator. Feel free to call if you have any questions. |
| If potentially eligible for services through the LEA, refer the child to the LEA and offer a Transition Planning Conference (TPC). If not potentially eligible for services through the LEA, explore other services, such as Head Start, child care, or private therapy. |
| Transition Options Discussed |
| Click here to enter text. |
| Outcome(s) for the Child and Family During This Transition |
| Click here to enter text. |
| Where will our joint planning begin? What are the steps to accomplish the transition and outcomes)? |
| Who will do what?  | When? |
| Click here to enter text. | Click here to enter text. |
| OTHER WPN |
| We propose: |
| Click here to enter text. |
| Other decision considered: |
| Click here to enter text. |
| This decision is recommended based upon (information and reasons): |
| Click here to enter text. |
| You have the right to agree with or refuse the proposed decision. Accompanying this document is a copy of the Parent and Child Rights and the actions to take if you do not agree with the proposed action. These are a brief review of the rights. If you would like a complete copy of the Parent and Child Rights, please contact your service coordinator. Feel free to call if you have any questions. |
| DISCHARGE WPN |
| Date of last day in the Birth to 3 Program: Enter date |
| Other decision considered: |
| Click here to enter text. |
| This decision is recommended based upon (information and reasons): |
| Click here to enter text. |
| You have the right to agree with or refuse the proposed decision. Accompanying this document is a copy of the Parent and Child Rights and the actions to take if you do not agree with the proposed action. These are a brief review of the rights. If you would like a complete copy of the Parent and Child Rights, please contact your service coordinator. Feel free to call if you have any questions. |
| If the child is potentially eligible for LEA services: |
|[ ]  Family opted out of LEA Notification by 2 years, 3 months of age. Date: Enter date |
|[ ]  LEA Notification (step 1) sent to school district: Enter date Date: Enter date |
|[ ]  Transition Planning Conference held. Date: Enter date |
|[ ]  Referral (LEA Notification, step 2) sent to school district: Enter date made at least 90 days before third birthday. Date: Enter date  |
|[ ]  Additional information, with signed consent, sent to LEA. Date: Enter date |
| **DEPARTMENT OF HEALTH SERVICES**Division of Medicaid ServicesF-00989K (02/2017) | **STATE OF WISCONSIN** |
| **TRANSITION PLAN—OTHER** |
| Child’s Name | Date of Report |
| Enter date | Enter date |
| A transition is any major event that impacts a child and family, such as moving out of the county or state, moving into or between programs, coming home from the NICU, changing a child care situation, or turning 3 years old.  |
| What kind of transition is this? |
|[ ]  Moved |[ ]  Individualized Family Service Plan met |
|[ ]  Family declines services |[ ]  Other: Enter date |
| Participants in the Transition Discussion |
| Click here to enter text. |
| Transition Options Discussed |
| Click here to enter text. |
| Outcome(s) for the Child and Family During This Transition |
| Click here to enter text. |
| Where will our joint planning begin? What are the steps to accomplish the transition and outcomes)? |
| Who will do what?  | When? |
| Click here to enter text. | Click here to enter text. |
| Other Written Prior Notice (WPN) |
| We propose: |
| Click here to enter text. |
| Other decision considered: |
| Click here to enter text. |
| This decision is recommended based upon (information and reasons): |
| Click here to enter text. |
| You have the right to agree with or refuse the proposed decision. Accompanying this document is a copy of the Parent and Child Rights and the actions to take if you do not agree with the proposed action. These are a brief review of the rights. If you would like a complete copy of the Parent and Child Rights, please contact your service coordinator. Feel free to call if you have any questions. |
| DISCHARGE WPN |
| Date of last day in the Birth to 3 Program: Enter date |
| Other decision considered: |
| Click here to enter text. |
| This decision is recommended based upon (information and reasons): |
| Click here to enter text. |
| You have the right to agree with or refuse the proposed decision. Accompanying this document is a copy of the Parent and Child Rights and the actions to take if you do not agree with the proposed action. These are a brief review of the rights. If you would like a complete copy of the Parent and Child Rights, please contact your service coordinator. Feel free to call if you have any questions. |
| **DEPARTMENT OF HEALTH SERVICES**Division of Medicaid ServicesF-00989L (02/2017) | **STATE OF WISCONSIN** |
| **SUMMARY OF SERVICES** |
| Child’s Name | Date of Report |
| Enter date | Enter date |
| Services and supports are determined following the development of functional Individualized Family Service Plan (IFSP) outcomes. They are designed to enhance the capacity of the family in supporting their child’s development and to promote the child’s learning and development through functional participation in family and community activities.**The following services are proposed by the Birth to 3 Program to be part of the IFSP:** |
| **Initial for Informed Consent** | **Person/Agency Role** | **Frequency/ Length** | **Intensity** | **Method of Delivery** | **Setting/ Location\*** | **Funding Source** | **Anticipated Start Date/ Anticipated Duration/ End Date** | **Type of Service** |
| enter date | enter date | enter date | enter date | enter date | enter date | enter date | Click here to enter text. | enter date |
| enter date | enter date | enter date | enter date | enter date | enter date | enter date | Click here to enter text. | enter date |
| enter date | enter date | enter date | enter date | enter date | enter date | enter date | Click here to enter text. | enter date |
| enter date | enter date | enter date | enter date | enter date | enter date | enter date | Click here to enter text. | enter date |
| enter date | enter date | enter date | enter date | enter date | enter date | enter date | Click here to enter text. | enter date |
| enter date | enter date | enter date | enter date | enter date | enter date | enter date | Click here to enter text. | enter date |
| **Written Prior Notice: Documentation of discussions to reach consensus about services.** [All WPN needs: (1) Services offered. (2) Other choices discussed. (3) Information (sources) used. (4) Reasons (details) for decisions. (5) Rights.]**The above services were proposed by the Birth to 3 Program to be part of this IFSP based upon the following information and reasons; the following service(s) or service options were discussed by the Birth to 3 Program but refused** (include information on “Other Options” discussions about any services refused or declined as well as any negotiations about frequency, intensity or method of service delivery, who the primary coach will be, etc.)**:** |
| Click here to enter text. |
| You have the right to agree with or refuse the proposed decision. Accompanying this document is a copy of the Parent and Child Rights and the actions to take if you do not agree with the proposed action. These are a brief review of the rights. If you would like a complete copy of the Parent and Child Rights, please contact your service coordinator. Feel free to call if you have any questions. |
| \*All services are provided in the natural environment for the child to the maximum extent appropriate; or justification is completed and attached. |
| Primary Location of Services |
|[ ]  Home |[ ]  Family child care |
|[ ]  Child care center |[ ]  Outpatient services |
|[ ]  Early intervention center |[ ]  Hospital |
|[ ]  Residential |[ ]  Not natural environment |
|[ ]  Natural Environment, Other: Enter date |
| **DEPARTMENT OF HEALTH SERVICES**Division of Medicaid ServicesF-00989M (02/2017) | **STATE OF WISCONSIN** |
| **JUSTIFICATION FOR SERVICES PROVIDED IN LOCATIONS OTHER THAN NATURAL ENVIRONMENTS** |
| Child’s Name | Date of Report |
| Enter date | Enter date |
| Services can be provided in settings other than a natural environment that are most appropriate, as determined by the Individualized Family Service Plan (IFSP) team, including the parent, only when early intervention services cannot be achieved satisfactorily in a natural environment. |
| List services and activities provided in a setting other than the child’s natural environment: |
| Click here to enter text. |
| Team recommendation based upon the IFSP outcome (explain why this service(s) will not be provided in the natural environment): |
| Click here to enter text. |
| How will the outcome be met in this setting? |
| Click here to enter text. |
| What activities will be provided to include this outcome in the child’s home and community environments? |
| Click here to enter text. |
| What is the plan to transition services back to the child’s home and community environments (with time frame)? |
| Who will do what?  | When? |
| Click here to enter text. | Click here to enter text. |
| **DEPARTMENT OF HEALTH SERVICES**Division of Medicaid ServicesF-00989N (02/2017) | **STATE OF WISCONSIN** |
| **OTHER SERVICES / COMMUNITY AND MEDICAL SUPPORTS** |
| Child’s Name | Date of Report |
| Enter date | Enter date |
| These are resources, supports or services that assist the child or family and are being pursued or are being received but not required or funded by the Birth to 3 Program. |
| Services family is currently receiving: |
| Click here to enter text. |
| Services needed: |
| Click here to enter text. |
| Steps to be taken to assist the child and family in securing these services: |
| Click here to enter text. |
| [ ]  IFSP team discussion found that no medical or other services were identified at this time. |
| **DEPARTMENT OF HEALTH SERVICES**Division of Medicaid ServicesF-00989P (02/2017) | **STATE OF WISCONSIN** |
| **INDIVIDUALIZED FAMILY SERVICE PLAN TEAM SIGNATURE** |
| Child’s Name | Date of Report |
| Enter date | Enter date |
|  |
| * I/we have received a copy of and understand the Parent and Child Rights.
* This Individualized Family Service Plan (IFSP) 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 IFSP will be shared with all team members listed below so they can work in partnership on behalf of my family.
 |
| **SIGNATURE** – Parent / Guardian | Date Signed | Print NameEnter date |
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| We have worked together with the family to create this IFSP and agree that this plan will guide our work. |
| **SIGNATURE** – IFSP Team Member | Date Signed | Print Name / TitleEnter date | Phone Numberenter date |
| **SIGNATURE** – IFSP Team Member | Date Signed | Print Name / TitleEnter date | Phone Numberenter date |
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