



WV Birth to Three
Office of Maternal, Child and Family Health
Bureau for Public Health
Department of Health and Human Resources

**Individualized Family
Service Plan (IFSP)**

Child's Name: _____
Child's DOB: _____
Date: _____

Individualized Family Service Plan

Under Part C of the IDEA, the purpose of the IFSP is to "enhance the capacity of families to meet the special needs of their children."

Type/Date of Meeting ☐ Initial IFSP _____

☐ Annual IFSP _____

Child's Name: _____ Date of Birth: _____

GENDER	
<input type="checkbox"/> M	<input type="checkbox"/> F

PRIMARY CONTACT	SECONDARY CONTACT
Parent/Foster Parent/Guardian/Family Member/Surrogate (Circle one)	Parent/Foster Parent/Guardian/Family Member (Circle one)
Name	Name
Address	Address
City State Zip	City State Zip
Phone (W) (H) (C)	Phone (W) (H) (C)
E-mail Address	E-mail Address
Primary Language Is Interpreter needed? Y / N	Primary Language Is Interpreter needed? Y / N
County of Residence	County of Residence
Alternate Contact (optional)	System Point of Entry Timelines (To be completed by Interim SC only)
Name	Date of Referral
Phone (W) (H) (C)	Date of Initial Contact
E-mail Address	Date of Intake
Initial Referral (To be Completed by Interim Service Coordinator)	Contact Information for When There Are Questions
Referral Source	RAU
Reason for Referral	Address
Address	Phone
Phone	Fax
Fax	Parent Partner
Interim Service Coordinator Contact Information	Ongoing Service Coordinator Contact Information
Name	Name
Address	Address
Phone	Phone
E-mail Address	E-mail Address



CHILD'S HEALTH HISTORY

Does your child have a primary care physician?

Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

What was the date of your child's last well child check up? _____

Are his/her immunizations current? Yes No

Was your child born early or prematurely? Yes No

If yes, how many weeks early was your child? _____

What was your child's:

Birth weight: _____ Birth Length: _____

How much does your child weigh now? _____

Were there any complications with your pregnancy or your child's birth?

Yes No If so, please describe.

Has your physician completed a developmental screen with your child?

Yes No If so, when was it done, and what were the results? May we ask for a copy?

Has your child's vision been previously screened or tested? Yes No

Do you have concerns now? Describe.

Has your child's hearing been previously screened or tested? Yes No

Do you have concerns now? Describe.

Does your child have frequent ear infections? Yes No

If yes, how many has your child had? How has the doctor treated them? (i.e. antibiotics, tubes, etc)

Does your child have any medical conditions or diagnosis? Yes No
If so, what is the medical condition or diagnosis and what has your doctor told you about it?

Does your child see any health specialists? Yes No

If so, who and what type?

Is your child currently taking any medications? Yes No

If so, what is it, and what is it for? Include any side effects.

Has your child ever been hospitalized? Yes No

Please tell us when, for how long and why?

What kinds of foods is your child eating? Do you have any questions about how your child eats or drinks?

Is there anything about your child's health (special equipment, allergies, family medical history) that the team should know about to better plan and provide services for your family?



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**SUMMARY OF FAMILY CONCERNS, PRIORITIES AND RESOURCES
AS THEY RELATE TO ENHANCING THEIR CHILD'S DEVELOPMENT**

(The family has given permission on the Notice and Consent for Multi-disciplinary Evaluation/Assessment form for this interview to be conducted)

Family's Areas of Concern: What concerns do you have about your child's development? Have you talked to your physician or anyone else about it? Do you want to meet other families who have a child with special needs?

Daily Routines: How does your child spend his/her day? What are your child's typical activities and routines (meal times, play, trips outside home) What are his/her favorite things to do? What are things that motivate your child? Tell us about your child's sleep patterns (bedtime, naps, hour of sleep) Are there people other than your immediate family that your child interacts with often?

Challenges: Are any parts of the day, routines, or activities difficult or challenging for your child? Do you have challenges in meeting your child's needs?



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Family: Who are the people living in your home? Who are the other important people in your family's life, especially those who can help you with your child's needs, or those who want to learn more about your child's development? Please include names and relationships.

Friends/Supports/Resources: Are there other agencies that you or your child receive services from? If so, do you receive care coordination or case management services from these agencies? Do you want to invite any of these people to be involved in the BTT meetings? Do you have health care insurance for your child? Do you want to be linked to financial resources that could help you with the cost of your child's special needs? Do you want to be linked to any other type of resources in your community?

Priorities: Which concerns that have been discussed would you like to focus on first? What do you hope WV Birth to Three can help you with?

Date of Family Interview: _____

Information Provided By: _____

Person Who Conducted Interview: _____

Signature



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ELIGIBILITY DETERMINATION FOR WV BIRTH TO THREE

The Part C evaluation and assessment of each child must be based on informed clinical opinion of the multi-disciplinary team, assuring multiple sources of information have been utilized to evaluate child and family needs. The Part C evaluation also serves as a developmental screen/assessment for EPSDT eligible children.

SUMMARY OF CHILD'S PRESENT LEVELS OF DEVELOPMENT

Provide a written description of the child's functional abilities within the daily activities and routines of the child and family.

Gross/Fine Motor Skills - The child's ability to use large and small muscles.

Receptive and Expressive Communication – The child's ability to understand and use language.

Cognitive including pre-literacy – The child's ability to learn and solve problems.

Social Emotional – The child's ability to interact with others, including self-control.

Self-Help/Adaptive Skills – The child's ability to help themselves in feeding, dressing, toileting.



Evaluation and Assessment Methods and Procedures

The following evaluation and assessment activities were completed as part of the multi-disciplinary evaluation/assessment process for determining eligibility and planning for IFSP development when appropriate:

- | | | |
|--|--|--|
| <input type="checkbox"/> REVIEW MEDICAL RECORDS | <input type="checkbox"/> CONSULTATION WITH HEALTHCARE PROVIDER | <input type="checkbox"/> FAMILY INTERVIEW |
| <input type="checkbox"/> OBSERVATION OF THE CHILD | <input type="checkbox"/> DEVELOPMENTAL SCREENING | <input type="checkbox"/> CURRICULUM BASED INSTRUMENT |
| <input type="checkbox"/> CRITERION REFERENCED INSTRUMENT | <input type="checkbox"/> NORM REFERENCED INSTRUMENT | <input type="checkbox"/> OTHER _____ |

Established Condition

MEETS CRITERIA
FOR THIS
CATEGORY

List all physical or mental condition(s) that the child has, from the WV Birth to Three State Eligibility policy, that have a high probability in resulting in developmental delay. If a condition is not listed in the WV Birth to Three State Eligibility policy, list the diagnosis only if the team has written confirmation from the child's physician that the diagnosis will result in substantial delay for this child. Written documentation of the Established Condition is required.

- ☐ YES
☐ NO

Does the child have a diagnosed vision impairment? ☐ YES ☐ NO
Does the child have a diagnosed hearing impairment? ☐ YES ☐ NO
List all other documented established conditions:

Developmental Delay

MEETS CRITERIA
FOR THIS
CATEGORY

Document all developmental areas where the child is experiencing a very substantial delay (40%), a substantial delay (25%) or atypical development. To be eligible a child must have 40% delay in one or more areas, a 25 % delay in two or more areas or atypical development in two or more areas. A child can be found eligible with a 25 % delay in one area and atypical development in another area. Written documentation supporting the developmental delay is required.

- ☐ YES
☐ NO

Adaptive Development	40% Delay	25% Delay	Atypical Development
Cognitive Development	40% Delay	25% Delay	Atypical Development
Communication Development	40% Delay	25% Delay	Atypical Development
Motor Development	40% Delay	25% Delay	Atypical Development
Social Emotional Development	40% Delay	25% Delay	Atypical Development

At-Risk Factors

MEETS CRITERIA
FOR THIS
CATEGORY

Document all risk factors as identified in WV Birth to Three State Eligibility policy, the child is experiencing that are likely to result in substantial developmental delay if early intervention services were not provided. To be eligible a child must be experiencing **at least 5 or more of the risk factors below**. Written documentation of the biological/medical risk factors is required.

- ☐ YES
☐ NO

Low Birth Weight	Severe Asphyxia	Small For Gestational Age	Chronic Otitis Media	Gestational Age
Technology Dependent	Child Abuse or Neglect substantiated by CPS	Family Barrier to Accessing Support	Serious Parental Concern	Primary Caregiver
Family Support Stressor	Chromosomal Abnormality/Genetic Disorder	Congenital Disorder	Severe Sensory Impairment	Nervous System Impairment
Inborn Error of Metabolism	Infectious Disease	Chronic Medical Illness	Perinatal Factor	Toxic Exposure

CHECK ALL
THAT APPLY



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<input type="checkbox"/>	As determined by the multi-disciplinary team, the child has been found eligible for WV Birth to Three. Date: _____
<input type="checkbox"/>	As determined by the multi-disciplinary team, the child is determined not eligible for WV Birth to Three because he/she did not meet any of the eligibility criteria. Date: _____
<input type="checkbox"/>	The child has been found eligible for WV Birth to Three, but the parent(s) have declined any further service. Date: _____

MULTI-DISCIPLINARY EVALUATION TEAM MEMBERS

Name/Signature/Credential	Date	Role on Team	Telephone/Email	Method of Contribution

- ☐ I/We agree with the determination of my/our child's eligibility/ineligibility.
☐ I/We disagree with the determination of my/our child's eligibility/ineligibility.
☐ I/We have received a written copy of the WV Birth to Three Procedural Safeguards.

If the child has been found to be ineligible, what other referrals/linkages have been made for the family?

Parent/Legal Guardian Signature

Date

Notice of Action: Eligibility Determination.

The 'Eligibility Determination for WV Birth to Three' section of this document summarizes the findings of the multidisciplinary evaluation team regarding this child's eligibility for WV Birth to Three. WV Birth to Three proposes this eligibility decision based on information gathered by the multidisciplinary team through the above referenced methods and activities. If you disagree with this decision, you have the rights as outlined in your Procedural Safeguards Booklet.

CHILD OUTCOME SUMMARY TOOL

The Child Outcome Summary Tool (COST) is to be used to assist the team, including the family, in evaluating and reporting the child's individual progress toward important developmental milestones as required by the U.S. Department of Education.

Type of COST completed today: ☐ **Initial COST*** ☐ **Annual COST** ☐ **Exit COST** Date[^]: _____

*** = COST not required if child is 30 months or older at initial IFSP**

^ = Enter date of Exit COST if done during annual meeting.



FAMILY and CHILD CENTERED OUTCOMES

Outcomes must be measurable and reflect the changes families would like to see happen for themselves and their children.

Outcome # ____ What changes would the family like to see happen for the child/family in the next six months? (The outcome must be functional, measurable, and achievable within the next six months.)

What criteria will the family and team use to measure this outcome to know that it has been achieved? (When will we review progress and what will progress look like?)

What's happening now related to this outcome? (Give detailed description here of what is currently happening related to the desired change/outcome?)

How will the family work toward achieving this outcome? (Describe the methods and strategies the family/caregivers will use to support their child during their daily activities and routines.)

People who will help and their roles. (List informal supports already available to the family prior to considering more formal supports. Informal supports that should be considered include: other family members or friends; special health care programs; or other early childhood or parent education programs that the family is involved with.)

This page may be duplicated as needed.



SERVICE COORDINATION OUTCOME

Family will receive assistance to evaluate and coordinate their WV Birth to Three services and to receive information and linkages to needed community resources.

The Service Coordinator will complete the following activities to support the child and family as needs are identified:

- ___ Assist the family in identifying the outcomes they would like to see for their child and family
- ___ Assist the family in identifying needs for community services and supports such as financial, medical, social, health or safety
- ___ Link the family to community services and supports to meet identified child and family needs
- ___ Coordinate and monitor (helping the family to evaluate) the timely delivery of available WV Birth to Three services
- ___ Coordinate an on-going communication process with all members of the child/family's IFSP team, including community partners and other care givers that the family would like to be involved
- ___ Coordinate with other case managers
- ___ Coordinate the performance of evaluations and assessments to re-determine eligibility and plan for annual IFSP
- ___ Coordinate and facilitate the development, review and evaluation of IFSP
- ___ Facilitate timely transition activities and the development of a transition plan, for every child exiting WV Birth to Three
- ___ Inform families of advocacy services

This family would like more information on and/or linkages for:

- ☐ Meeting with other families of children with special needs
- ☐ Finding or working with doctors or other specialists
- ☐ Dental care for my child
- ☐ Resources to help meet my child's nutritional needs
- ☐ How different services work or how they could work better for my family
- ☐ Planning for the future; what to expect
- ☐ Respite care, so we can have a break
- ☐ Activities for children in our community
- ☐ Leisure/recreational activities
- ☐ Community supports for housing, clothing, jobs, food, telephone
- ☐ Information on my child's special needs, what it means
- ☐ Ways to involve brothers, sisters, friends, extended family
- ☐ Support groups within our community, region or state
- ☐ Family leadership opportunities
- ☐ Education opportunities for our family
- ☐ Getting a GED
- ☐ Accessing child care
- ☐ Accessing transportation
- ☐ Programs and services for my child at age three
- ☐ Obtaining a copy of my child's birth certificate or immunization record
- ☐ Other _____



SERVICES IN NATURAL ENVIRONMENTS

To the maximum extent appropriate to the needs of the child, early intervention services must be provided in natural environments.

Related to Outcomes #:	Part C Service	AT Services Y/N	Location (Settings for services)	Intensity and Frequency (How often, how long)	Method	Start Date	Anticipated Duration	Funding Source	Parent Consent/Initials
		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Home <input type="checkbox"/> Child care <input type="checkbox"/> Community setting/NE <input type="checkbox"/> Hospital Inpatient <input type="checkbox"/> Residential Facility	____min.- ____xs/	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C			<input type="checkbox"/> BTT/CFO <input type="checkbox"/> Other_____	
		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Home <input type="checkbox"/> Child care <input type="checkbox"/> Community setting/NE <input type="checkbox"/> Hospital Inpatient <input type="checkbox"/> Residential Facility	____min.- ____xs/	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C			<input type="checkbox"/> BTT/CFO <input type="checkbox"/> Other_____	
		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Home <input type="checkbox"/> Child care <input type="checkbox"/> Community setting/NE <input type="checkbox"/> Hospital Inpatient <input type="checkbox"/> Residential Facility	____min.- ____xs/	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C			<input type="checkbox"/> BTT/CFO <input type="checkbox"/> Other_____	
		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Home <input type="checkbox"/> Child care <input type="checkbox"/> Community setting/NE <input type="checkbox"/> Hospital Inpatient <input type="checkbox"/> Residential Facility	____min.- ____xs/	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C			<input type="checkbox"/> BTT/CFO <input type="checkbox"/> Other_____	
		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Home <input type="checkbox"/> Child care <input type="checkbox"/> Community setting/NE <input type="checkbox"/> Hospital Inpatient <input type="checkbox"/> Residential Facility	____min.- ____xs/	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C			<input type="checkbox"/> BTT/CFO <input type="checkbox"/> Other_____	
		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Home <input type="checkbox"/> Child care <input type="checkbox"/> Community setting/NE <input type="checkbox"/> Hospital Inpatient <input type="checkbox"/> Residential Facility	____min.- ____xs/	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C			<input type="checkbox"/> BTT/CFO <input type="checkbox"/> Other_____	

Method Codes:

A=Direct therapeutic developmental activities with the child designed to enhance the child's development.

B=Providing the family and/or caregivers with information, skills, and support to enhance the development of the child.

C=Providing support and consultation to a child's caregivers to increase the child's participation within community-based learning opportunities.



SERVICES NOT PROVIDED IN NATURAL ENVIRONMENTS

"The provision of early intervention services for any infant or toddler occurs in a setting other than the natural environment only when early intervention cannot be achieved satisfactorily in a natural environment." 636(a)(5)

Related to Outcomes #:	Part C Service	AT Services Y/N	Location (Settings for Services)	Intensity/ Frequency (How often, how long)	Method	Start Date	Anticipated Duration	Funding Source	Parent Consent/Initials
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Service provider location <input type="checkbox"/> Program-children w/disabilities	____ min. – ____ xs/	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C			<input type="checkbox"/> BTT/CFO <input type="checkbox"/> Other_____	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Service provider location <input type="checkbox"/> Program-children w/disabilities	____ min. – ____ xs/	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C			<input type="checkbox"/> BTT/CFO <input type="checkbox"/> Other_____	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Service provider location <input type="checkbox"/> Program-children w/disabilities	____ min. – ____ xs/	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C			<input type="checkbox"/> BTT/CFO <input type="checkbox"/> Other_____	

Method Codes: A=Direct therapeutic activities B=Providing the family and/or caregivers with information C=Providing support and consultation to caregivers

NATURAL LEARNING OPPORTUNITIES JUSTIFICATION - "If services are delivered in other than natural environments, include a justification as to why early intervention could not be achieved in a natural environment."

Why outcome/strategies cannot be satisfactorily achieved in daily settings.	How will strategies and activities be included in the daily settings?	Plan and time line to move service into daily settings.



“OTHER SERVICES/SUPPORTS” NEEDED BUT NOT REQUIRED UNDER PART C OF IDEA

To the extent appropriate, the IFSP must include services that are not required or covered under Part C but are necessary to promote the health, safety, and well-being of the child and/or family.

Service or Support	List steps to be taken to secure services	Potential funding source

- ☐ This family has chosen not to be linked to other services.

NOTE:

*The following community resources may help families to access ‘other’ needed services and supports:
WIC, SSI, WVCHIP, Medicaid, InRoads, CDCSP, CSHCN, NEMT, PERC, DD Council-Partners in Policymaking, WVPTI,
WVA, Title XIX Waiver, Family Support, Child Care R&Rs, WVECTCR, OMCFH Toll-Free Line (System Point of Entry).*

Direct links to most of these resources may be found on the WV Department of Health and Human Resources homepage (www.wvdhhr.org) or the WV Birth to Three website under ‘Resources’. Parent Partners in each Regional Administrative Unit can provide additional information for resources in their community.



IFSP TEAM MEMBERSHIP

Each agency or person who has a direct role in the provision of services is responsible for making a good faith effort to assist the eligible child and his/her family in achieving the outcomes on the child's IFSP.

Name and Signature/Credential	Date	Contact Information (Address, Phone, E-mail, Best Time to Call)	Contributed but not present (Include Method of contribution)

Parent's Informed Consent for WV Birth to Three Services:

- ☐ I/We have helped develop this Individualized Family Service Plan(IFSP). I/We understand and agree with its content. I/We agree to each of the services I/We have initialed. I/We understand that my consent for services may be withdrawn by written request at any time.
- ☐ I/We do not accept this IFSP as written, however I /We do give permission for the following services to begin: _____
- ☐ I/We have received a copy of the Procedural Safeguards. Our Interim/Ongoing Service Coordinator has reviewed our rights and answered any questions I/We have.

Parent/Legal Guardian Signature

Date

Notice of Action – IFSP Development: The IFSP is the documentation of the multi-disciplinary team's decision for the provision of early intervention services for each child found eligible for WV Birth to Three. The IFSP identifies the services and supports needed to achieve the IFSP outcomes as identified by the MDT team. WV Birth to Three is proposing to implement this plan of early intervention services that have been individualized to meet the needs of the child and family listed above.