RI Early Intervention Individualized Family Service Plan

Program Information

In Early Intervention

We want children of all abilities to …

- ***Demonstrate positive emotional skills, including social relationships***
- ***Acquire and use knowledge and skills; including early literacy skills***
- ***Use appropriate behaviors to meet their needs***

We want all families to…

- ***Understand their children's strengths, abilities, and special needs***
- ***Know their rights and effectively communicate their children's needs***
- ***Help their children develop and learn***

My Child's Name:

DOB: **Gender:** ☐ **Male** ☐ **Female**

ID#: **Referral Date:**

Child's Address:

1.) Parent/Guardian:

Phone:

Email:

2.) Parent/Guardian:

Phone:

Email:

Service Coordinator

Phone: **ext.**

Email:

Parent Consultant:

Phone: **ext.**

Primary Care Physician:

PCP Address and Phone #:

IFSP Meeting Date: **(Date the IFSP team meets to begin development of the IFSP)**

45 days from referral is
If the initial IFSP is over 45 days from referral indicate why:
☐ Child hospitalization ☐ Family requested delay ☐ Unable to contact/Family cancellation ☐ Provider issue

IFSP Start Date: **(Date the family agrees to and signs the IFSP)**

6 Month Review Date

RBI Completion Date:

If this is an Interim IFSP complete Cover Page, page 10,11 and 13.

RI Early Intervention Individualized Family Service Plan
Your Family, Supports and Resources

Child's Name _____ DOB _____ Age _____ ID_____ Date _____

Please describe the reason your child was referred to Early Intervention (EI):

General Health *(Consider ▪ Child's growth/ development / medical history ▪ Pertinent family history or other important events ▪ Medications taken/reasons ▪ Established conditions ▪ Prematurity ▪ Pregnancy and birth summary (only if relevant to reason for referral)*

Has your child's lead level been tested? ☐ Yes ☐ No
Is there a concern for a high lead level? ☐ Yes ☐ No
If Yes, Please explain.

Tell us about your child's nutrition and feeding (i.e. food preferences, diet, intake, swallowing, chewing):

Sleep? (i.e. hours, patterns, routines):

RI Early Intervention Individualized Family Service Plan

Child's Name DOB Age ID Date

Tell us about your general daily activities? (i.e. diapering, bathing, behavior, going out in the community):

Does your child spend any time in a licensed early care and education setting? ☐ Yes ☐ No

Caregiver Location/Name:

Schedule:

Hours/week:

Does your child spend any time in the care of another non-parental adult? ☐ Yes ☐ No

Caregiver Location/Name:

Schedule:

Hours/week:

Other helpful information

Please share any information that may be helpful in supporting your families culture such as important holidays, cultural traditions, church, food, customs:

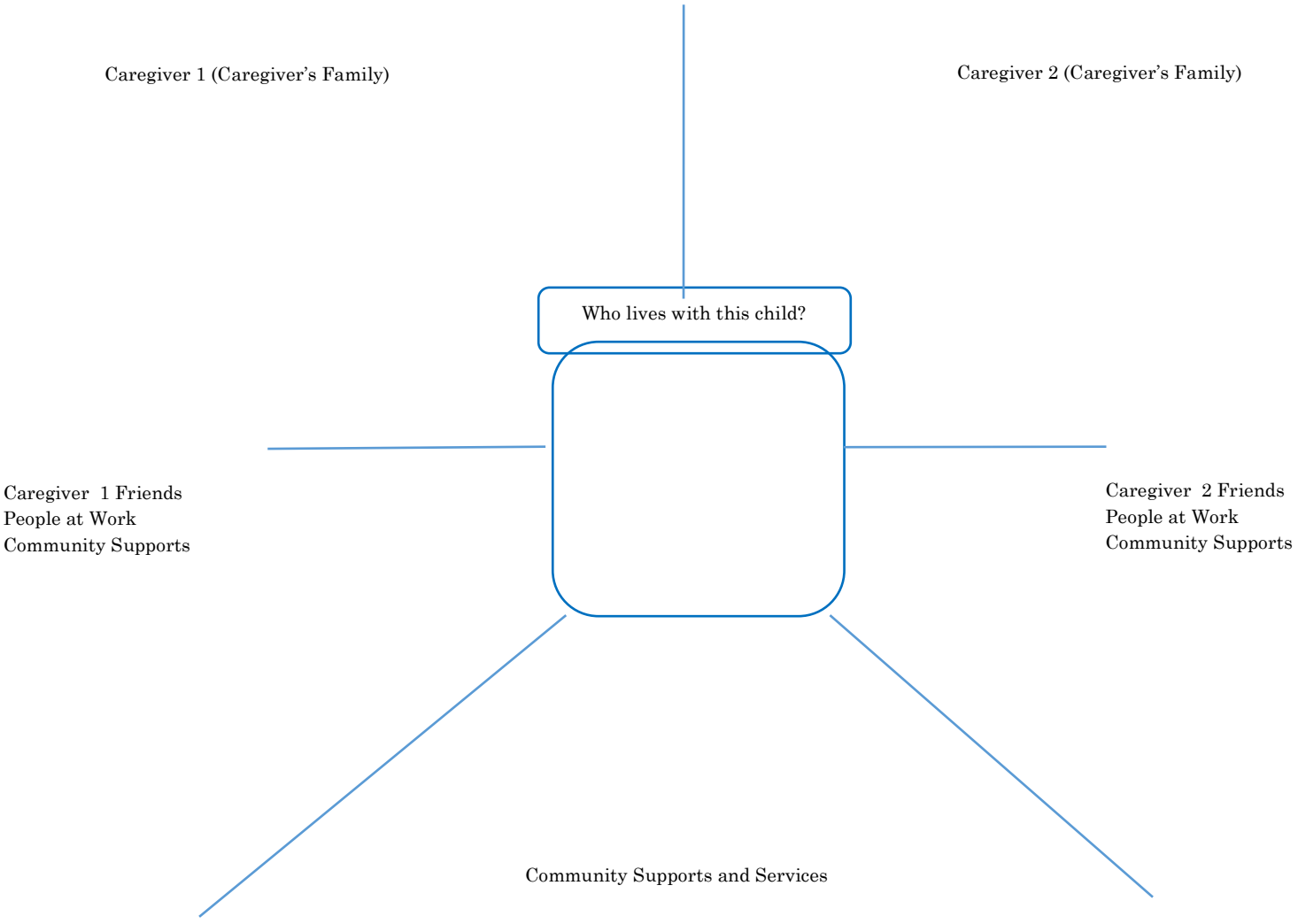
RI Early Intervention Individualized Family Service Plan
Your Family, Supports and Resources

Child's Name DOB Age ID Date

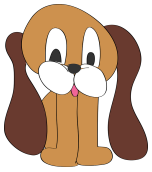
THIS PAGE SHOULD BE FILED SEPARATELY FROM THE IFSP AS IT MAY CONTAIN SENSITIVE INFORMATION. This will prevent it from being copied outside EI.

Are there any other circumstances affecting your child and family that could impact your child's development? (i.e. safety, homelessness, trauma, illness, loss, financial stress, depression, addiction)?

☐ **Initial EcoMap developed.** *An ECOMAP is a picture of the supports that surround your family. This picture will help us to get to know you better. The space in the center represents who lives with your child. We will draw lines that connect your family to those around you. The thicker the line the more supportive the relationship. Broken lines or dashes represent relationships that cause you stress. Please consider extended family, friends, and places of worship, clubs, pediatricians or specialist or agencies like WIC. This information will help EI get a better picture of your family's supports and resources and will help us support you in the development of individualized ideas and strategies.*



RI Early Intervention Screening for Hearing Loss or Change in Hearing Level

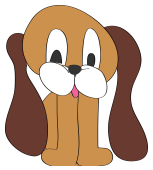


Child's Name DOB Age ID Date

Column 1			Column 2			
Yes	**No**		**Yes**	**No**	**NA or Not Sure**	
☐	☐	Do you have any concerns about how your child hears?				Approximately how many spoken words or gestures does your child use consistently? words gestures Compare this infomation to the developmental milestones expected for children this age. Any child with words/gestures like that of a younger child should be referred for a hearing assessment.
☐	☐	Do you have any concerns about your child's language development?				
☐	☐	Has anyone else expressed concern about how your child hears? If yes, who? _____				
☐	☐	Has anyone else expressed concerned about your child's language development? If yes, who? _____	☐	☐	☐	Did your child pass his/her newborn hearing screening?
☐	☐	Has your child had middle ear infections or fluid in the ears for more than 3 months?	☐	☐	☐	At 2 months, did/does your child coo or make gurgling sounds and turn his/her head toward sounds?
☐	☐	Does your child have a medical condition associated with hearing loss (see a example list on back)?	☐	☐	☐	At 4 months, did/does your child babble with expression and copy sounds he/she hears?
☐	☐	Has your child had meningitis?	☐	☐	☐	At 6 months does your child respond to his/her name?
☐	☐	Has your child experienced head trauma or excessive exposure to noise?	☐	☐	☐	At 9 months, did/does your child turn toward familiar voices and sounds in the environment?
☐	☐	Has your child experienced any serious illness requiring hospitalization?	☐	☐	☐	At 12 months, did/does your child say single words such as "ma-ma", "da-da"?
☐	☐	Does your child have a craniofacial anomaly, such as cleft palate that was not identified at birth?	☐	☐	☐	At 18 months, did/does your child follow or respond to simple questions? "Come here" "Where's your shoe?"
			☐	☐	☐	At 18 months, does/did your child say have at least 10 single words, e.g. "puppy", "milk", "cookie"
			☐	☐	☐	At 24 months, did/does your child use two or three word phrases to talk or ask for things?

*If you answered **"yes" to any questions in Column 1 and/or "no" to any question in Column 2,** it is recommended that you schedule a comprehensive hearing test for your child by a licensed pediatric audiologist. Testing will ensure your child is hearing all the sounds we would expect. A copy of this hearing screening should be given to the audiologist.*

RI Early Intervention Screening for Hearing Loss or Change in Hearing Level



Child's Name DOB Age ID Date

Based on the results of this assessment:

☐ ***We recommend your child receives a comprehensive hearing assessment with a pediatric audiologist*** ***(enter FER on Evaluation Summary page)***

☐ *Parents/Guardian has received* ***RI Guide to Your Child's Hearing Assessment****, which includes a list of pediatric audiologists*

☐ ***We have learned your child is currently being followed by an audiologist*** ***(enter FER on Evaluation Summary page)***

Audiologist Name: Dr.

Child's next scheduled appointment is on

☐ ***No concerns have been identified at this time. Your child will continue with standard periodic screenings by their pediatrician and EI will revisit this screening at, or before the annual IFSP review*** ***(enter WNL on Evaluation Summary page)***

Parents/Guardian: If applicable, remember to give your consent for Early Intervention to obtain a copy of your child's audiologic report.

Are you unsure if your child passed their newborn hearing screen?

If your child was born in RI, results can be obtained from the RI Hearing Assessment Program (phone 401-277-3700, fax 401-921-6937). You can call directly, or your EI provider can assist you. If you would like your EI provider to obtain this information on your behalf, you will be asked to sign consent before the request can take place. If the child was born out of state and you are unaware if their child was tested or what the results were, you can consult **www.infanthearing.org** to obtain contact information for that state.

Does your child have a medical condition associated with hearing loss?

There are over 300 syndromes associated with hearing loss. This is a list those that are more common. All children with these diagnoses should be followed closely by a pediatric audiologist.

- Achondroplasia
- Alport
- Apert
- Branchio-Oto-Renal Syndrome
- Charcot-marie-Tooth
- CHARGE Syndrome
- Crouzen or Cornelia de Lange
- Fetal Alcohol Syndrome
- Goldenhar Syndrome
- Hunter Syndrome
- Mitochondrial Conditions
- Neurofibromatosis
- Pendred
- Oculo-Auriculo-Vertebral Dysplasia
- Stickler Syndrome
- Treacher Collins
- Trisomy 13 or 18
- Trisomy 21 (Down Syndrome)
- Turner Syndrome
- Usher Syndrome
- Waardenburg Syndrome

RI Early Intervention Screening for Vision Loss or Changes in Vision

Child's Name DOB Age ID Date

Column 1			Column 2			
Yes	**No**		**Yes**	**No**	**NA**	
☐	☐	Do you have any concerns about your child's vision? If yes, please explain _____				**At 0-3 months, did/does your child:**
			☐	☐	☐	Smile at other people?
☐	☐	Did you/other parent wear corrective lenses as a child?	☐	☐	☐	Look at their own hands?
☐	☐	Have you/other parent ever had a medical condition related to your eyes?	☐	☐	☐	Look at parent(s) as they enter the room?
☐	☐	Do your child's eyes appear to cross, turn in or wander?				**At 4 – 6 months, did/does your child?**
			☐	☐	☐	Watch a ball drop on the floor and roll away?
☐	☐	Are your child's pupils or eyes different sizes?	☐	☐	☐	Look back and forth between 2 objects?
☐	☐	Have you noticed any rapid back and forth movement of your child's eyes?	☐	☐	☐	Notice something small like a raisin when it is 12 inches away?
			☐	☐	☐	Reach and grasp at toys?
☐	☐	Does your child press on or poke at their eye(s)?				**At 7-9 months, did/does your child?**
☐	☐	Does your child tilt or turn their head in an unusual way when looking at something?	☐	☐	☐	Look for dropped toys?
			☐	☐	☐	Attempt to move toward an object that is at least 5 feet away?
☐	☐	Was your child born prematurely or on oxygen while in the hospital?	☐	☐	☐	Try to grab hair, jewelry or glasses?
☐	☐	Does your child ever bring objects very close to their face in order to see better?	☐	☐	☐	Pick up or attempt to pick up a small object?
☐	☐	Does your child ever squint? If yes, when? _____				**At 10 – 18 months, does/did your child?**
☐	☐	Does your child have a health condition associated with vision loss (see examples on next page)? Or other diagnosis or medical concerns? If yes, please explain_____ _____	☐	☐	☐	React to facial expressions of others such as frowns or smiles?
			☐	☐	☐	Show an interest in picture books?
			☐	☐	☐	Reach in to a container and pull out objects easily?
			☐	☐	☐	Notice objects or people outside through a window?

*If you answered **"yes" to any questions in Column 1 and/or "no" to any question in Column 2,** it is recommended that you schedule a comprehensive eye exam for your child by a pediatric optometrist or ophthalmologist. A copy of this vision screening should be given to the eye care provider, as well as your child's pediatrician.*

RI Early Intervention Screening for Vision Loss or Changes in Vision

Child's Name DOB Age ID Date

Based on the results of this assessment:

☐ ***We recommend your child receives a comprehensive eye examination with a pediatric optometrist or ophthalmologist*** ***(enter FER on Evaluation Summary page)***

☐ Parents/Guardian has received ***RI Guide to Your Child's Vision,*** which includes a list of pediatric *optometrists and ophthalmologists*

☐ ***We have learned your child is currently being followed by an optometrist or ophthalmologist*** ***(enter FER on Evaluation Summary page)***

Optometrist /Ophthalmologist Name: Dr. _____

Child's next scheduled appointment is on _____/_____/_____

☐ ***No concerns have been identified at this time. Your child should continue with recommended screenings by their pediatrician and EI will revisit this screening at, or before the annual IFSP review*** ***(enter WNL on Evaluation Summary page)***

Parents/Guardian: If applicable, remember to give your consent for Early Intervention to obtain a copy of your child's eye examination report.

There are many medical conditions that can impact a child's vision. This is a list of some that will require a child to be closely followed by a pediatric ophthalmologist.

- Strabismus
- Congenital Cateracts
- Congenital Glaucoma
- Retinal Degeneration
- Optic Atrophy
- Tuberous Sclerosis
- Marfan syndrome
- Cerebral Palsy
- Osteogenesis Imperfecta
- Galactosemic
- Hypocystinuria
- CHARGE syndrome
- Trisomy 13
- Trisomy 18
- Down Syndrome
- Albinism

The American Academy of Ophthalmology and the American Association for Pediatric Ophthalmology and Strabismus recommend the following schedule for pediatric vision screening:

Newborn. *An ophthalmologist, pediatrician, family doctor or other trained health professional should examine a newborn baby's eyes and perform a red reflex test (a basic indicator that the eyes are normal). An ophthalmologist should perform a comprehensive exam if the baby is premature or at high risk for medical problems for other reasons, has signs of abnormalities, or has a family history of serious vision disorders in childhood.*

Infant. *A second screening for eye health should be done by an ophthalmologist, pediatrician, family doctor or other trained health professional at a well-child exam between six months and the first birthday*

Preschooler. *Between the ages of 3 and 3½, a child's vision and eye alignment should be assessed by a pediatrician, family doctor, ophthalmologist, optometrist, orthoptist or person trained in vision assessment of preschool children.*

American Academy of Ophthalmology 2019
https://www.aao.org/eye-health/tips-prevention/children-eye-screening

Portions of this screening are adapted from: Heiting OD, Gary (2017). Your Infant's Vision Development. Retrieved from https://www.allaboutvision.com/parents/infants.htm

RI Early Intervention Evaluation Summary

Child's Name DOB Age ID Date

Where was the evaluation conducted?

Was the child's behavior and participation typical? surprising? Please explain.

Evaluation Team:

(Including Family) Name/Role: Name/Role: Name/Role:

Name/Role: Name/Role: Name/Role:

Methods / Procedures Used For Evaluation/Assessment: Check all that apply: ☐ *Standardized tool*

☐ *Checklist* ☐ *Review of medical record* ☐ *Interview* ☐ *Observation. Please list other methods and procedures on the lines below:*

☐ **Eligible:** This child meets the eligibility criteria for early intervention services.

Check #1 OR #2

1. ☐ **Single Established Condition (Specify)**

Primary Reason for Eligibility: ICD-10 Code:

Secondary Reason for Eligibility: ICD-10 Code:

2. ☐ **Significant Developmental Delay (Select Eligibility Category a, b, or c)**

Primary Reason for Eligibility: ICD-10 Code:

a) A delay of 2 standard deviations in at least one of the following area(s)

☐ Cognitive ☐ Gross Motor ☐ Fine Motor Skills ☐ Expressive Communication

☐ Receptive Communication ☐ Social Emotional ☐ Adaptive Skills

b) A delay of 1.5 standard deviations in at least two of the following area(s)

☐ Cognitive ☐ Gross Motor ☐ Fine Motor Skills ☐ Expressive Communication

☐ Receptive Communication ☐ Social Emotional ☐ Adaptive Skills

c) There is a significant impact on child/family functioning in the following area(s)

☐ Cognitive ☐ Gross Motor ☐ Fine Motor Skills ☐ Expressive Communication

☐ Receptive Communication ☐ Social Emotional

☐ Adaptive Skills ☐ Vision ☐ Hearing ☐ Health ☐ Family Circumstance

☐ **Not Eligible:** This child does not meet the eligibility criteria for EI services *(Summarize on Form B).* ***Reminder: Provide procedural safeguards and document on Services Rendered Form.***

☐ **Family declined Early Intervention services**

Scores: Indicate Standard Score (SS) (This is the same as Composite Score) **Results**: Indicate if 2 SD or 1.5 SD, WNL (Within Normal Limits) or SIF (Significant Impact on Functioning). If result is less than 1.5 SD, indicate <1.5 SD. Significant Impact on Functioning must be described in Child Outcomes Summary Section B. For Hearing and Vision use WNL or FER (Further Evaluation Recommended). *Please note: 2 SD below mean = (SS=70 or below), 1.5 SD below mean = (SS=71-77) and in general, Standard Scores (SS) between 85 and 115 are considered to be within normal limits.*

Developmental Area Reviewed	Score	Results	Developmental Area Reviewed	Score	Results	Developmental Area Reviewed	Score	Results
Cognitive			Gross Motor Skills			Vision	N/A	
Expressive Communication			Social Emotional			Hearing	N/A	
Receptive Communication			Adaptive Skills			Family Circumstance	N/A	
Fine Motor Skills			Health	N/A		**Response to Referral Source:** If this is the initial evaluation, did you send a response to the referral source? ☐Yes ☐No ☐N/A		

RI Early Intervention Individualized Family Service Plan
Child and Family Outcomes

Child's Name DOB Age ID Date

Child Outcome Summary (COS) Section B:

Use multiple sources of information, including COS Section A, to describe this child's functioning in each outcomes area. Identify how these skills compare to same age peers using language such as age expected, skill like that of a younger child and/or a much younger child.

Information provided by: ☐ Parent/Guardian ☐ Caregiver ☐ EC Teacher ☐ EI/ECSE Educator ☐ EI/ECSE Therapist ☐ Other

Outcome 1: Positive Social Emotional Skills (Including Social Relationships):

Involves how the child relates to adults and other children, and for older children, how the child follows rules related to interacting with others. The outcome is measured based on how the child forms secure relationships with adults and children, expresses feelings, learns rules and expectations, and interacts socially.

Skills expected of a child this age (age expected)

Skills like that of a younger child; lead to age-expected (immediate foundational)

Skills of a much younger child; earlier skills (foundational)

Other observations and information

RI Early Intervention Individualized Family Service Plan
Child and Family Outcomes

Child's Name DOB Age ID Date

Outcome 2: Acquiring and Using Knowledge and Skills: Involves thinking and reasoning, remembering, problem solving, using symbols and language, and understanding the physical and social world. The outcome is measured based on a child's exploration and imitation, as well as his or her understanding of object permanence, symbolic representation, numbers, classification, spatial relationships, expressive language and communication, and for older children, early literacy.
Skills expected of a child this age (age expected)
Skills like that of a younger child; lead to age-expected (immediate foundational)
Skills of a much younger child; earlier skills (foundational)
Other observations and information

RI Early Intervention Individualized Family Service Plan
Child and Family Outcomes

Child's Name DOB Age ID Date

Outcome 3: Taking Action to Meet Needs: Involves communicating/taking care of basic needs such as showing hunger, getting from place to place, using tools like a fork, toothbrush or crayon, and for older children, contributing to their own health and safety. The outcome is measured based on a child's ability to integrate motor skills to complete tasks, self-help skills (e.g., dressing, feeding, grooming, toileting, and household tasks), and "act on the world to get what one needs."
Skills expected of a child this age (age expected)
Skills like that of a younger child; lead to age-expected (immediate foundational)
Skills of a much younger child; earlier skills (foundational)
Other notable observations and information

RI Early Intervention Individualized Family Service Plan

Child and Family Outcomes

Child's Name DOB Age ID Date

Child Outcomes Summary (COS) Section C

How would you summarize this child's development in each outcome area? Review and select a statement for each outcome and record in the box below.

- Relative to same age peers, this child has all the skills we would expect for a child his/her age. (7)
- Relative to same age peers, this child has the skills we would expect for a child his/her age, however there are concerns that he/she may be on the border of not keeping up with same age peers. (6)
- Relative to same age peers, this child shows many age expected skills, but also shows some functioning that might be described like that of a slightly younger child. (5)
- Relative to same age peers, this child shows occasional use of some age expected skills, but more of his/her skills are not yet age expected. (4)
- Relative to same age peers, this child is not yet using skills expected of his/her age but does use many important and immediate foundational skills upon which to build. (3)
- Relative to same age peers, this child is showing some emerging or immediate foundational skills upon which to build. (2)
- Relative to same age peers, this child's functioning might be described as that of a much younger child. He/she shows some early skills but not yet any immediate foundational or age expected skills. (1)

	Outcome	Numerical Rating (Chose one for each Outcome)	Exit Only: Has this child made progress in this outcome? (Choose one for each Outcome)
1	**Positive Social Emotional Skills (Including Social Relationships)**		☐ YES ☐ NO
2	**Acquiring and Using Knowledge and Skills**		☐ YES ☐ NO
3	**Taking Action to Meet Needs**		☐ YES ☐ NO
No *exit* rating due to: ☐ Child enrolled less than 6 months ☐ Lack of information due to loss of contact with child/family			

RI Early Intervention Individualized Family Service Plan

Child and Family Outcomes

Child's Name DOB ID#

Outcomes are like goals…they reflect the changes families would like to see happen for themselves and their children. They are based on your concerns and priorities and are related to the development of your child. We will make them measurable so we can track progress.

# _____a.) What we want to see happen for our child/family as a result of early intervention supports and services?	**Date Written** **Date Reviewed** ☐Periodic /6 Mo. ☐Annual IFSP Other **Parent Initials** _____
b.) How will we know your child/family has made progress?	***Additional Review:*** **Date Reviewed** **Parent Initials** _____
c.) Progress Review: Outcome is: ☐Continued ☐Achieved ☐Modified/New Outcome Written	
# _____a.) What we want to see happen for our child/family as a result of early intervention supports and services?	**Date Written** **Date Reviewed** ☐Periodic /6 Mo. ☐Annual IFSP Other **Parent Initials** _____
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Child and Family Outcomes

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RI Early Intervention Individualized Family Service Plan

Child and Family Outcomes

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b.) How will we know your child/family has made progress?	**Additional Review:** **Date Reviewed** **Parent Initials** _____
c.) Progress Review: Outcome is: ☐Continued ☐Achieved ☐Modified/New Outcome Written	

Child's Name DOB ID#

RI Early Intervention Individualized Family Service Plan

Child and Family Outcomes

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RI Early Intervention Individualized Family Service Plan

Child and Family Outcomes

Child's Name DOB ID#

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c.) Progress Review: Outcome is: ☐Continued ☐Achieved ☐Modified/New Outcome Written	
# _____a.) What we want to see happen for our child/family as a result of early intervention supports and services?	**Date Written** **Date Reviewed** ☐Periodic /6 Mo. ☐Annual IFSP Other **Parent Initials** _____
b.) How will we know your child/family has made progress?	**Additional Review:** **Date Reviewed** **Parent Initials** _____
c.) Progress Review: Outcome is: ☐Continued ☐Achieved ☐Modified/New Outcome Written	

RI Early Intervention Individualized Family Service Plan
Early Intervention Services

Child's Name DOB ID#

Check and date applicable area ☐ Interim: ☐ Initial: ☐ Annual:	☐ Update:

Services and supports are determined after IFSP outcomes are developed.

EI Service	**Provider** (Name)	**Location**	**Method** I/G	*** Natural Setting** Yes / No	**Frequency** (# of times per wk/mo)	**Intensity** (length of session)	**Date of Initiation**	**Duration** (months)	**Status** A Add E End

*** If NO, complete page 12 "Plan for Providing Services in the Natural Environment"**

Services:
- Assistive technology
- Audiology
- Family Training/Counseling
- Nursing services
- Nutrition
- Occupational therapy
- Physical therapy
- Psychology
- Social work
- Speech/language therapy
- Vision

Location Codes:
H (*Home)* ***C (****Community)*
EIGC *(EI Group in the Community)*
CB *(Center Based)*
N/A *(Not Applicable)*

Method:
I *(Individual)*
G *(Group)*

Service Coordination is provided to coordinate services on the IFSP and could consist of home visits, telephone calls, and conversations with other providers. Early Intervention is able to provide interpretation, translation, and transportation services for families as needed to access EI programs and services.

Services that are in place or are needed: (services such as medical, recreational, religious or social, while not covered by Early Intervention, contribute to this plan)

Program/Agency	**Contact**	**Status**

Complete this Section for Updates and Annual IFSP Review Only

Parental Consent: I understand and agree to the changes in the IFSP services listed above. I also understand that this is my prior written notice to starting the services listed above.

Parent/Guardian Signature:_____

Date_____/_____/_____

RI Early Intervention Individualized Family Service Plan
Plan for Providing Services in the Natural Environment

Child's Name DOB ID#

Service/Location:
Explain why the child's outcome(s) could not be achieved if service were provided in the child's natural environment? *(What are the barriers? How does the team know?)*
How will the family participate in achieving this outcome? *(How will the family be coached to practice these strategies and skills in everyday routines and activities?)*
What is needed to address this outcome within the child's typical daily routines and family activities? *(Who is responsible? What is the timetable? What is needed? How will the family be supported?)*
Review Date: ☐ Continue ☐ Change ☐ Achieved Please summarize child's progress and changes that would be helpful:
Review Date: ☐ Continue ☐ Change ☐ Achieved Please summarize child's progress and changes that would be helpful:

RI Early Intervention Individualized Family Service Plan

Child's Name DOB ID#

Acknowledgement of the IFSP

☐ I give my consent to implement this Individualized Family Service Plan for my child and family as written.

☐ I give my consent to implement this Individualized Family Service Plan for my child and family with the following changes:

☐ I understand that early intervention services will be paid by private health insurance, Medicaid or state funds.

☐ I understand that this is my prior written notice to begin the services listed on the IFSP.

☐ I have received a copy of my procedural safeguards. These rights have been explained to me and I understand them.

Parent/Guardian Signature: Date:

Other Team Member: Date:

~ For Interim IFSPs Only~

I understand that this is an Interim IFSP and that it is a temporary plan developed for children who are eligible for Early Intervention and are in need of immediate services. I also understand that a full IFSP still needs to be completed.

Parent's initials: Date: / /