At-Risk Individualized Family Support Plan (At-Risk IFSP)

Spell Check

Your Family's Information

Child's Information

Child's Name: _____ _____ _____ _____
Last First MI AKA

DOB: _____ Child ID #: _____ Gender: _____

Caregiver(s)

Caregiver Type: _____
Caregiver Name(s): _____
Address: _____
City: _____ Zip Code: _____ County: _____
Cell Phone: _____ Home Phone: _____ Work Phone: _____ Ext: _____
Best time to call: _____ Email: _____

Caregiver Type: _____
Caregiver Name(s): _____
Address: _____
City: _____ Zip Code: _____ County: _____
Cell Phone: _____ Home Phone: _____ Work Phone: _____ Ext: _____
Best time to call: _____ Email: _____

Language

Child's Primary Language/Mode of Communication: _____ _____
Primary Language Used in Home/Mode of Communication: _____ _____
Is an Interpreter needed for the family? _____

IFSP Information

Referral Date: _____ Screening Date: _____ _____ _____ _____
Initial IFSP Date: _____ Periodic IFSP Date: _____ _____ _____ _____
Annual IFSP Date: _____ Current IFSP Date: _____
IFSP Type: Date Child turning 3: _____
○ Periodic ○ Annual Transition Due Between: _____ & _____

Contact Information

Agency: _____
Service Coordinator: _____
Phone: _____ Ext: _____ Fax: _____ Email: _____
Address: _____ City: _____ Zip: _____
Family Resource Specialist: _____
Phone: _____ Ext: _____ Fax: _____ Email: _____
Address: _____ City: _____ Zip: _____

Getting to Know Your Child and Family	
Family: Who lives in your household?	
Name:	Relationship:
	Self (Child)

Successes: What success would you like to share about your child's development? What are your favorite family experiences with your child?
Concerns: What are your most important concerns about your child's development? What difficulties does your family/child experience during your daily routine?
Priorities: What are your priorities? What would you like Early Steps to focus on?
Additional Information: Is there anything else you would like to share?

Health Status & Developmental Screening

Date information gathered: _____ Chronological age: _____ months

Physician Information

Primary Pediatrician: _____
Office Name: _____
Address: _____
City: _____ **State:** FL **Zip Code:** _____
Phone: _____ **Fax:** _____

Other Physician(s)	Phone	Physician Type	Add Physician

Insurance Information

Primary Insurance	Member ID	Group/MED Type	Policy Holder	DOB
Secondary Insurance				

Bill Private Insurance: _____

Tell us about your child's health:

Was your child born full term? _____ Date of child's last well check: _____
How many weeks? _____ Birth Weight: 0 0 oz. or 0 g Are immunizations current? _____
At-Risk Condition:

Plan for Developmental Surveillance

Tools/methods used (check all that applies):

☐ Developmental Checklists (specify) ☐ Parent Report or Observation ☐ Record review
☐ Developmental monitoring ☐ Ages & Stages ☐ CDC Milestone Tracker
☐ Other: _____

Surveillance Frequency: _____

Program Responsible: _____

Summary of Child's Developmental Status:

Does the child's developmental status indicate potential eligibility for developmental delay or established condition in any of the following areas:

☐ Adaptive ☐ Social-Emotional ☐ Communication ☐ Fine Motor ☐ Gross Motor ☐ Cognitive ☐ No

Does the child meet additional eligibility criteria due to:

Established Condition	☐ Yes	☐ No
Developmental Delay	☐ Yes	☐ No
Informed Clinical Opinion Which Contradicts Scores	☐ Yes	☐ No

If any box is checked Yes, insert date here _____ and begin a new IFSP

Next Steps:

Child Na , -
Child DOB:

Service Coordinator:
IFSP Date:

Your Child's Service Coordination/Targeted Case Management Plan

Your Service Coordinator's name is . He/she can be reached by phone at and by email at . The family Resource Specialist, , is also available to provide parent support. He/she can be reached at or by email at .

Targeted Case Management Review Date(s): _____ _____ _____

Below are medical or additional supports your child and family receive or would like help receiving that are not required or covered by Early Steps:

Medical or additional supports your child or family receives or would like assistance with:

Child Care/Enrichment	Currently Receiving	Would Like Help Receiving	NA
Before/After Childcare	☐	☐	☐
Camps	☐	☐	☐
Child Care/Enrichment	☐	☐	☐
Early Head Start/Head Start	☐	☐	☐
Parenting Classes	☐	☐	☐
Income Assistance			
Emergency Financial Support	☐	☐	☐
Food Stamps/SNAP	☐	☐	☐
Low Income Housing	☐	☐	☐
Public Assistance/TANF	☐	☐	☐
SSI/SSDI	☐	☐	☐
Transportation	☐	☐	☐
WIC	☐	☐	☐
Medical/Health			
Counseling Assistance	☐	☐	☐
Dental Services	☐	☐	☐
Home Health Care	☐	☐	☐
Immunizations	☐	☐	☐
Medical Insurance	☐	☐	☐
Mental Health Care	☐	☐	☐
Substance Abuse	☐	☐	☐
Nutrition Classes	☐	☐	☐
Prenatal Care	☐	☐	☐
Primary Health Care	☐	☐	☐
Other			
Accessibility	☐	☐	☐
Adult Education	☐	☐	☐
Equipment	☐	☐	☐
Recreation Programs	☐	☐	☐
Safety	☐	☐	☐
Support Groups	☐	☐	☐
Other:	☐	☐	☐
Other:	☐	☐	☐

Additional Notes:

Your Child's Service Coordinator/Targeted Case Management Goals:

Person Responsible for Providing Assistance or Support	Date of Referral/Activity	Agency/Individual to Whom Child/Family is Referred	Referrals/Activities to be Completed by Service Coordinator

Services Needed to Achieve Early Intervention Outcomes

The below services are recommended by your team to support your family in meeting the developmental needs of your child. You have the right to accept or decline some or all the recommended services.

Service Description	Provider Name & Phone	Location	Auth. Start Date	Auth. End Date	Payer

Individualized Family Support Plan Team includes the members below:

Member Name:	Role:
	Parent/Caregiver
	Parent/Caregiver
	Service Coordinator

Informed Consent by Parent/Guardians

☐ I have participated fully in this plan.

☐ A copy of my procedural safeguards (summary of family rights) has been explained and provided to me.

☐ I give consent for Individualized Family Support Planning, service coordination, developmental surveillance, and family support.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Consent for Services for Children in Custody of Department of Children and Families (DCF) Under Chapter 39, F.S.

I give consent for medical care and treatment per Section 743.0645, Florida Statutes, and as modified in this IFSP

DCF Caseworker/Designee Signature: _____ Date: _____

Transition

The Transition plan outlines the steps and services to support your child and family as you leave Early Steps.

Preparing for Your Transition Conference

The following are options your family is interested in after your child turns three:

- ☐ Local school district (Pre-K)
- ☐ Head Start
- ☐ Agency for Persons with Disabilities
- ☐ Early care and education programs
- ☐ Other: _____

☐ The Understanding Notification Brochure was provided. Date: _____

Notification was provided to the local school district. _____ Date: _____

Notification was provided to the Department of Education. _____ Date: _____

Additional information regarding Notification, if applicable:

Your Transition Conference

Transition Conference Date: _____

What are your most important questions or concerns regarding your child's transition from Early Steps?

The following activities will occur to address your questions and concerns:

The below agency/programs provided information regarding their services that included the evaluation/eligibility process:

The following activities will support your child's transition into a new setting/environment:

Family will:	Timeline	Agency/Program will:	Timeline	Service Coordinator will:	Timeline

We attended the transition conference and participated in the development of this transition plan.

_____ _____

Parent/Guardian Parent/Guardian

_____ _____

Service Coordinator Local School District Representative

_____ _____

Program/Agency Representative Program/Agency Representative

_____ _____

Other Other