EARLY DEVELOPMENT NETWORK
Nebraska Individualized Family Service Plan (IFSP)

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Child's Name	Telephone	Address
Child's Birthdate		Child's Medicaid Number
Date of Referral to Early Intervention	Date of Consent for Evaluation	Date of MDT
Family's Language Choice		Family would like an Interpretor ☐ Yes ☐ No

Parent(s) /Guardian:

Name	Home Phone	Address (if different)
Role	Work Phone	Address (if different)
Name	Home Phone	Address (if different)
Role	Work Phone	Address (if different)
Name	Home Phone	Address (if different)
Role	Work Phone	Address (if different)
Name	Home Phone	Address (if different)
Role	Work Phone	Address (if different)

If you have any questions about this plan or any of the people working with your child, please call the person listed as Services Coordinator.

Name	Phone	Agency Address

IFSP Meeting Dates:

Interim Date/Date Sent	Initial Date/Date Sent	Annual Date/Date Sent	Date Sent
Periodic Review Date/Date Sent	Periodic Review Date/Date Sent	Periodic Review Date Sent	Periodic Review Date/ Date Sent

Name of Child

Date	Family's Concerns and Desired Priorities

Name of Child

Date	Child and Family's Strengths

Name of Child

Child's Present Level of Development

Area/Date of Evaluation

Vision	Years	Months	Current Abilities
Vision (Update)	Years	Months	Current Abilities
Hearing	Years	Months	Current Abilities
Hearing (Update)	Years	Months	Current Abilities
Health Status	Years	Months	Current Abilities
Health Status (Update)	Years	Months	Current Abilities

(- - - - -) Denotes Periodic Update **CONFIDENTIAL**

Name of Child

Child's Present Level of Development

Area/Date of Evaluation

Cognitive Thinking Skills	Years	Months	Current Abilities
Cognitive Thinking Skills (Update)	Years	Months	Current Abilities
Communication Skills	Years	Months	Current Abilities
Communication Skills (Update)	Years	Months	Current Abilities
Social Behavior Skills	Years	Months	Current Abilities
Social Behavior Skills (Update)	Years	Months	Current Abilities

(- - - - -) Denotes Periodic Update **CONFIDENTIAL**

Name of Child

Child's Present Level of Development

Area/Date of Evaluation

Self-Help/Adaptive Skills	Years	Months	Current Abilities
Self-Help/Adaptive Skills (Update)	Years	Months	Current Abilities
Fine Motor Skills	Years	Months	Current Abilities
Fine Motor Skills (Update)	Years	Months	Current Abilities
Gross Motor Skills	Years	Months	Current Abilities
Gross Motor Skills (Update)	Years	Months	Current Abilities

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Name of Child

Outcome

Child/Family strengths and resources related to this outcome

What will be done by whom

Progress will be reviewed

By whom_____ How Often_____Through How Measured_____

Plan Review for this Outcome

Date

Next steps comments

How much progress

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Child/Family strengths and resources related to this outcome

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Date

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How much progress

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School District	Name of Child

IFSP Transition Plan

Transition Conference Date	Estimated Transition Date

What Needs to be Done	Who is Responsible	Time Line	Date Completed

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Name of Child

Family Choice: Consent to the continuation of early intervention services or initiation of special education services

I/we have received a copy of the Annual Transition Notice.

I/We have been informed about the differences between, and the right to choose, early intervention services provided through an IFSP under the Individuals with Disabilities Education Act (IDEA) and the preschool special education services provided through an Individualized Education Program (IEP) under IDEA once my/our child reaches age 3 .

I/We understand that if I/we choose for my/our child to receive special education services through an IEP, my child and family will no longer receive early intervention services nor will receive early intervention services coordination.

I/We understand that if I/we choose for my/our child to continue to receive early intervention services through an IFSP, at any time I/we may elect to receive special education preschool services instead of early intervention services.

I/We understand that my/our consent to the continuation of early intervention services is voluntary and that I/we may revoke consent at any time

☐ I/we consent to the continuation of early intervention services for my/our child and family through an IFSP after my/our child's third birthday.

☐ I/We request initiation of preschool special education services for my/our child and family at or after age 3.

Parent/Guardian Signature	Date
Parent/Guardian Signature	Date

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School District	Name of Child
☐ Interim ☐ Initial ☐ Annual ☐ Periodic Review	Date

Are there special conditions for safe transportation for this child?

The Services that will be provided to support all goals and objectives

Service	Location (Where)? Group/Individual? Natural Environment?	Frequency? Length? Method?	Duration When will the Service Start/End?	Who Pays

Include a justification of the extent, if any, to which a service will not be provided in a natural environment.

Name of Child

Other Services/Supports the Child/Family is receiving or needs but is not required nor funded by the Early Intervention Program.

Service Description	Start/End Date	Person Responsible	Funding Source

HOME AND COMMUNITY-BASED WAIVER SERVICES/SUPPORTS THAT WILL BE PROVIDED TO SUPPORT WAIVER OUTCOMES:

Service	To Help With Outcome	How Much	Service Start/End Date	Funding Source

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Name of Child

Child/Family Team

Team members present at the meeting ☐ Interim ☐ Initial ☐ Annual ☐ Periodic Review		Date		
Name	**Signature**	**Role**	**Address**	**Phone**

Others Who are Part of the Child/Family Team

Name	**Role**	**Address**	**Phone**	**Family Initial for Copy of Pages Sent**

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Name of Child

Parent's/Family Informed Consent

The early intervention services will be provided as described in the IFSP and must begin no later than 30 days from the date of my/our written consent. I/We understand that the IFSP will be reviewed at least every six (6) months.

I/We understand that my/our consent is voluntary and that I/we may revoke consent at any time.

I/We have been informed of the determination(s) of the IFSP team in my/our native language or other mode of communication.

I/We understand we can accept or decline any service listed in the IFSP without jeopardizing receipt of other services we accept in the plan.

I (we) understand that a copy of the IFSP, evaluation, child assessment and family assessment will be distributed within 7 calendar days.

I/We understand the plan and parental rights and give permission to implement this IFSP, and give consent for all services in the IFSP.

Parent/Guardian Signature	Date
Parent/Guardian Signature	Date

I/We do not agree with the proposed IFSP as written. However, I/we do consent to the following services/frequency:

Parent/Guardian Signature	Date
Parent/Guardian Signature	Date