

EARLY INTERVENTION PROGRAM
Nebraska Individualized Family Service Plan (IFSP)

CONFIDENTIAL

Child's Name: _____

Phone: _____

Address: _____

Child's Birthdate: _____

Social Security Number: _____

Medicaid Number: _____

Date of Referral to Early Intervention _____

Date of Consent for Evaluation _____

Date of MDT _____

Family's language choice: _____

Family would like an Interpreter Yes No

Parent(s)/Guardian:

Name: _____

Home Phone: _____

Address (if different) _____

Role _____

Work Phone: _____

Name: _____

Home Phone: _____

Address (if different) _____

Role _____

Work Phone: _____

Name: _____

Home Phone: _____

Address (if different) _____

Role _____

Work Phone: _____

Name: _____

Home Phone: _____

Address (if different) _____

Role _____

Work Phone: _____

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 sent) Initial _____ / _____ (Date sent) Annual _____ / _____ (Date sent)

Periodic Review _____ / _____ (Date sent) Periodic Review _____ / _____ (Date sent) Periodic Review _____ / _____ (Date sent) Periodic Review _____ / _____ (Date sent)



Name of Child _____

CONFIDENTIAL

DATE: FAMILY'S CONCERNS AND DESIRED PRIORITIES:

Empty space for writing concerns and priorities.

Name of Child _____

CONFIDENTIAL

DATE CHILD AND FAMILY'S STRENGTHS:

(----- Denotes Periodic Update)

Name of Child _____

CONFIDENTIAL

CHILD'S PRESENT LEVELS OF DEVELOPMENT

Area/Date of Evaluation

Current Abilities

Vision / ___ / ___ / ___ ___ yrs ___ mos _____

----- /-----/----- / ----- yrs ----- mos -----

Hearing ___ / ___ / ___ / ___ yrs ___ mos _____

----- /-----/----- / ----- yrs ----- mos -----

Health / ___ / ___ / ___ ___ yrs ___ mos _____
 Status

----- /-----/----- ----- yrs ----- mos -----

(----- Denotes Periodic Update)

Name of Child _____

CONFIDENTIAL

CHILD'S PRESENT LEVELS OF DEVELOPMENT (CONT'D)

Area/Date of Evaluation

Current Abilities

Cognitive/
Thinking Skills

___ / ___ / ___ / ___ yrs ___ mos

---- / ---- / ---- / ---- yrs ----- mos

Communication
Skills

___ / ___ / ___ / ___ yrs ___ mos

---- / ---- / ---- / ---- yrs ----- mos

Social/Behavior
Skills

___ / ___ / ___ / ___ yrs ___ mos

---- / ---- / ---- / ---- yrs ----- mos

(----- Denotes Periodic Update)

Name of Child _____

CONFIDENTIAL

CHILD'S PRESENT LEVELS OF DEVELOPMENT (CONT'D)

Area/Date of Evaluation

Current Abilities

Self-Help/Adaptive Skills

___ / ___ / ___ / ___ yrs ___ mos

----- /-----/ ---- / ----- yrs ----- mos

Fine Motor Skills

___ / ___ / ___ / ___ yrs ___ mos

/---- /-----/ ---- yrs ----- mos

Gross Motor Skills

___ / ___ / ___ / ___ yrs ___ mos

----- /-----/ ---- / ----- yrs ----- mos

Name of Child _____

CONFIDENTIAL

GOAL/OUTCOME:

Goal/Outcome _____

Child/Family strengths and resources related to this goal:

What will be done/by whom:

Progress will be reviewed _____ by _____ through _____
(How Often) (By Whom) (How Measured)

Name of Child _____

CONFIDENTIAL

GOAL/OUTCOME:

Plan Review for this Goal

Date

How much progress

Next Steps:/Comments:

School District # _____ Name of Child _____

CONFIDENTIAL

IFSP TRANSITION PLAN

Transition Conference Date: _____ Estimated Transition Date: _____

What Needs
to be Done

Who is
Responsible

Time
Line

Date
Completed

School District # _____ Name of Child _____

CONFIDENTIAL

IFSP TRANSITION PLAN

Transition Conference Date: _____ Estimated Transition Date: _____

What Needs
to be Done

Who is
Responsible

Time
Line

Date
Completed

Parent's/Family

I (we) understand the content of the IFSP and give consent for all services in the IFSP to begin unless indicated below. Yes ___ No ___

I(we) understand that a copy of the IFSP will be distributed within 7 calendar days. Yes ___ No ___

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Any Comments: