EARLY DEVELOPMENT NETWORK
Nebraska Individualized Family Service Plan (IFSP)

CONFIDENTIAL

Child's Name:	Phone:	Address:
Child's Birth date:		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:	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 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:

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DATE:	FAMILY'S CONCERNS AND DESIRED PRIORITIES

Name of Child:

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DATE:	CHILD AND FAMILY'S STRENGTHS

(------ Denotes Periodic Update) **Name of Child:**

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CHILD'S PRESENT LEVELS OF DEVELOPMENT

Area/Date of Evaluation			**Current Abilities**
Vision	_____	_____ yrs _____ mos	
	----------	---------- yrs ---------- mos	
Hearing	_____	_____ yrs _____ mos	
	----------	---------- yrs ---------- mos	
Health Status	_____	_____ yrs _____ mos	
	----------	---------- yrs ---------- mos	

(------ Denotes Periodic Update) **Name of Child:**

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CHILD'S PRESENT LEVELS OF DEVELOPMENT

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:**

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CHILD'S PRESENT LEVELS OF DEVELOPMENT

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:

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OUTCOME

Outcome:

Child/Family strengths and resources related to this outcome:

What will be done/by whom:

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

Plan Review for this Outcome

Date: Next Steps:/Comments:

How much progress:

Name of Child:

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OUTCOME

Outcome:

Child/Family strengths and resources related to this outcome:

What will be done/by whom:

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

Plan Review for this Outcome

Date: Next Steps:/Comments:

How much progress:

+ Click to add more outcome

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

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: _____

School District # **Name of Child:**

CONFIDENTIAL

☐ 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	How often? Where Group/Individual? Natural Environment?	How much?	When will the service Start/End?	Who pays?	Who's responsible?

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

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

Name of Child:

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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

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: _____