Program Information Here

early intervention

supporting families and child development

Rhode Island Department of Human Services
Early Intervention Program

Individualized Family Service Plan

Child's Name: _____ **ID :**_____

DOB: _____/_____/_____ **Gender:** ☐ **Male** ☐ **Female**

Service Coordinator: _____ **Ext #** _____

Child's Address _____

Parent Consultant: _____ **Ext #** _____

_____

Primary Care Physician: _____

Parent/Guardian:_____

Phone # _____**Referral Date:** _____/_____/_____

IFSP Meeting/Review Date: _____/_____/_____
(This is the date when the IFSP team meets to begin the development of the IFSP.)

If the initial IFSP is over 45 days from referral or the annual IFSP is over 12 months, please indicate why:

- ☐ Child hospitalization
- ☐ Family requested delay
- ☐ Provider issue
- ☐ Unable to contact/Family cancellation

IFSP Start Date: _____/_____/_____ **IFSP End Date:** _____/_____/_____
(The start date is the date the family signs the IFSP in agreement.)

Type of IFSP:

- ☐ Interim (Complete pages 1, 11, 12 and 15) Date: _____/_____/_____
- ☐ Initial
- ☐ Annual

Six Months Review due on or before: _____/_____/____

Rhode Island Early Intervention Individualized Family Service Plan

Child's Name: _____ ID: #_____

About My Child: ▪Where and with whom does your child spend time?

▪Describe the people, toys, activities, routines, and places your child enjoys the most and the ones he/she finds challenging (If this is an annual IFSP, what's new? Has anything changed?)

About My Family: ***You may share as much or as little information as you choose***

▪ People, places and activities my family enjoys ▪ Great things about our family, our strengths (If this is an annual IFSP, what's new? Has anything changed?)

Family's Questions for the Assessment:

Rhode Island Early Intervention Assessment Summary

Child's Name: _____ ID#: _____

DOB: _____/_____/_____ Evaluation Date: _____/_____/_____

Chronological Age: _____ Child's Adjusted Age: _____

Physical and Behavioral Health History:

▪Pregnancy and birth history ▪History of child's growth and development ▪Medical History ▪Immunizations ▪Pertinent family history or other important events

_____

_____

_____

_____

_____

_____

_____

_____

Current Health Status

▪Medications child is currently taking ▪Reason for taking medication ▪Last well-child check-up ▪Medical Specialists ▪Medical Diagnosis ▪Nutrition

_____

_____

_____

_____

_____

_____

_____

_____

_____

Rhode Island Early Intervention Assessment Summary

Child's Name: _____

ID#: _____

We want all children to:

- *have positive social relationships*
- *learn and use knowledge and skills*
- *take appropriate action to meet their needs*

Vision Status

EI Vision screening completed? ☐Yes ☐No ▪If Yes, summarize results. ▪If No, evaluated elsewhere? Where? When? Summarize results.

_____

_____

_____

_____

Hearing Status

EI Hearing screening completed? ☐Yes ☐No ▪If Yes, summarize results. ▪If No, evaluated elsewhere? Where? When? Summarize results.

_____

_____

_____

_____

Rhode Island Early Intervention Assessment Summary

Child's Name: _____ ID#_____

We want all children to:
- *have positive social relationships*
- *learn and use knowledge and skills*
- *take appropriate action to meet their needs*

Introduction

▪Family's initial concerns ▪Reason for referral ▪Family's role during evaluation ▪Behavioral observation of the child

Cognitive Skills: Playing, Thinking and Exploring

▪Present levels of development ▪Strengths in this area ▪Concerns in this area ▪How does this impact the child's participation in everyday routines and typical activities? ▪Are the child's skills age appropriate?

Rhode Island Early Intervention Assessment Summary

We want all children to:
- *have positive social relationships*
- *learn and use knowledge and skills*
- *take appropriate action to meet their needs*

Child's Name: _____ ID#_____

Gross Motor Skills: Body and Muscle Development, Moving

▪Present levels of development ▪Strengths in this area ▪Concerns in this area ▪How does this impact the child's participation in everyday routines and typical activities? ▪Are the child's skills age appropriate?

Fine Motor Skills: Body and Muscle Development, Using Hands

▪Present levels of development ▪Strengths in this area ▪Concerns in this area ▪How does this impact the child's participation in everyday routines and typical activities? ▪Are the child's skills age appropriate?

Rhode Island Early Intervention Assessment Summary

Child's Name: _____ ID#_____

We want all children to:
- *have positive social relationships*
- *learn and use knowledge and skills*
- *take appropriate action to meet their needs*

Receptive Communication: Understanding

▪Present levels of development ▪Strengths in this area ▪Concerns in this area ▪How does this impact the child's participation in everyday routines and typical activities? ▪Are the child's skills age appropriate?

Expressive Communication: Communicating

▪Present levels of development ▪Strengths in this area ▪Concerns in this area ▪How does this impact the child's participation in everyday routines and typical activities? ▪Are the child's skills age appropriate?

Rhode Island Early Intervention Assessment Summary

Child's Name: _____ ID#_____

We want all children to:
- *have positive social relationships*
- *learn and use knowledge and skills*
- *take appropriate action to meet their needs*

Adaptive Skills: Eating, Dressing, Toileting, Sleeping

▪Present levels of development ▪Strengths in this area ▪Concerns in this area ▪How does this impact the child's participation in everyday routines and typical activities? ▪Are the child's skills age appropriate?

Social/Emotional Skills: Interacting with Others

▪Present levels of development ▪Strengths in this area ▪Concerns in this area ▪How does this impact the child's participation in everyday routines and typical activities? ▪Are the child's skills age appropriate?

Rhode Island Early Intervention Evaluation Summary

Child's Name: _____ ID#: _____ Evaluation Date: _____/_____/_____

Disposition:
☐ Eligible ☐ Family decline services at this time ☐ Ineligible

Eligibility:
☐ Single Established Condition
☐ Developmental Delay
☐ Developmental Delay by Informed Clinical Opinion
☐ Multiple Established Conditions (List 4 conditions. One must be a child condition)

1. _____ Code: _____
2. _____ Code: _____
3. _____ Code: _____
4. _____ Code: _____

Methods and Procedures Used:

☐ Review of medical record
☐ Developmental history
☐ Family report
☐ Routines-based interview
☐ Observation of child
☐ Language sample
☐ Play-based evaluation

Evaluation/Assessment Used:

☐ Developmental checklist:
_____
☐ Criterion/curriculum based Instrument:
_____
☐ Norm referenced Instrument:
_____
☐ Other:
_____

Diagnosis:

Primary Diagnosis: _____ ICD-9 Code: _____

Secondary Diagnosis: _____ ICD-9 Code: _____

Additional Diagnosis: _____ ICD-9 Code: _____

Additional Diagnosis: _____ ICD-9 Code: _____

Participants:

Name: _____ Role: _____

Name: _____ Role: _____

Name: _____ Role: _____

Name: _____ Role: _____

Response to Referral: If this is the initial evaluation, did you send the response to referral? ☐Yes ☐No ☐N/A

Results Summary: Results include Standard Score, T-score, developmental age, performance level, or whether or not concerns were identified. (Please note that in general, Standard Scores (SS) between 85 and 115 are considered to be within normal limits, as are T-scores between 40 and 60)

Data Code: 1-7 score may be 1-4, 6. 8-9 should be only 4 or 6.
1. >=2 SD or at least 33% delay
2. Delay 1.5 to 2 SD
3. Delay<1.5 SD or at least 25% delay
4. Health Risk or impairment significant atypical findings
6. No delay or significant findings

Area Reviewed	Results	Data Code	Comments:
1. Cognitive			
2. Gross Motor			
3. Fine Motor			
4. Receptive Communication			
5. Expressive Communication			
6. Adaptive Skills			
7. Social Emotional			
8. Vision			
9. Hearing			

Child's Name: _____ ID#: _____

Family Concerns and Priorities

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*
- *have adequate social support*
- *be able to access services and activities available to all families in their communities*

I want more information about:

- ☐Playing with my child
- ☐Ideas for involving brothers, sisters, and friends
- ☐Meeting with other families who have similar concerns
- ☐Opportunities for my child to play with other kids
- ☐Respite
- ☐Managing stress
- ☐More ways to have fun as a family
- ☐My child's condition or disability
- ☐Finding or communicating with doctors/dentist
- ☐Equipment, supplies and/or assistive technology
- ☐Money for costs related to the special needs of my child
- ☐Housing, job, food and/or phones
- ☐Safety
- ☐Legal issues
- ☐Getting a GED or other schooling
- ☐Substance abuse
- ☐Other:

_____

_____

Thinking about all of the information we've gathered up until now, what are your current concerns related to your child's development?

List any other concerns identified by other team members during the assessment process.

Looking at this list what would you like to focus on in the next few months?

Child's Name: _____ ID#: _____ Date _____/_____/_____

Outcome

What we want to see happen for our child/family as a result of early intervention supports and services:

_____

What is happening now and describe how this impacts your child /family? (Who, What, When, Where, How?)

_____

_____

_____

_____

What will happen? (What will progress look like?/How you will know it is happening or describe the steps toward progress)

_____

_____

Our Strategies: (WHAT strategies, and in WHICH everyday routines, activities and places? What supports does the caregiver need to utilize the strategies?)

_____

_____

_____

_____

Review Date: _____/_____/_____ ☐Continue Outcome ☐Change Outcome ☐Achieved Outcome Parent's initials:_____ Date: _____/_____/_____

Please summarize child's progress and changes that would be helpful:

Review Date: _____/_____/_____ ☐Continue Outcome ☐Change Outcome ☐Achieved Outcome Parent's initials:_____ Date: _____/_____/_____

Please summarize child's progress and changes that would be helpful:

Child's Name: _____ ID#: _____

Early Intervention Services

☐Interim: _____/_____/_____ ☐Initial: _____/_____/_____ ☐Progress Review: _____/_____/_____ ☐Annual: _____/_____/_____

*EI Services	Provider (Name)	Location [1] (1-5)	Method of Service *(C/G/I)	Natural Setting[2] Yes/No	J	Frequency (#of times per wk/mo)	Intensity (length of session)	Proposed Initiation Date	Duration (months)	*Timeliness of Service	Status A= Add E= End

IFSP Update Date of Change: _____/_____/_____ Parent's initials: _____	Describe changes made to services and reason for the change:
IFSP Update Date of Change: _____/_____/_____ Parent's initials: _____	Describe changes made to services and reason for the change:

[1] Refer to Code Key on next page.

[2] If NO, is there a justification? If there is a justification write **"J"** in 2nd column. If there is no justification please complete page 14 "Plan for Providing Services in a Natural Environment".

Code Key and Other Services

Child's Name: _____ ID#: _____

Services		Location	Method	Timeliness of Service
• Assistive technology • Audiology • Family Training/Counseling • Medical services • Nursing services • Nutrition services • Occupational therapy • Other Needs: specify • Physical Therapy	• Psychology • Social work • Special instruction • Speech/language • Vision	**1=** Home **2=** Community Based **3=** EI Group in the Community **4=** Center Based **5=** NA	**C**= Consult/Evaluation **G**= Group **I**= Individual	**C=** Community schedule **S=** Staggering services **F=** Family issue **P=** Provider issue

- Service Coordination is provided to all families and could be part of a visit. At least 30 minutes per month of face-to-face service coordination must be provided.
- Transition planning is part of Service Coordination and will be provided to all families.
- Interpretation/Translation and Transportation are services available to all families as needed.

Other 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:

Plan for Providing Services in a Natural Environment

Child's Name: _____ ID#_____ DOB: _____/_____/_____

Service/location:
Outcome(s) addressed:
1. Describe why outcome(s) cannot be achieved in the child's natural environment (based on assessment/experience):
2. Describe how these activities/strategies will be applied to child's daily activity/routines:
Who will do **What** and **How Often** to generalize?
3. Describe plan for moving to a natural environment?
Who will do **What** by **When**?
Review Date: _____/_____/_____ ☐Continue ☐Change ☐Achieved Please summarize child's progress and changes that would be helpful:

Child's Name: _____ ID#: _____

Acknowledgement of the IFSP

I have **PARTICIPATED** in the development of this IFSP, I have **READ** this IFSP and/or the contents of the IFSP have been **FULLY EXPLAINED** to me.

_____ I have been informed of my right to due process and procedures (procedural safeguards).

_____ I understand that Early Intervention services will be paid for by private health insurance, Medicaid, and/or state funds.

_____ I understand that Service Coordination could consist of home visit time, telephone calls, and conversations with other providers.

I can anticipate Service Coordination to be provided _____. I understand that this can be amended at any time with agreement from the IFSP Team.
(amount of time per month)

_____ I **do** approve of this plan for my child and family.

_____ I **do not** approve of this plan and I would like the following changes made: _____

_____

_____

_____ I understand that services on my IFSP should start within 30 days of my signature, unless there is a justified reason indicated.

IFSP Team Members:

Parent/Guardian Signature:_____ Date: _____/_____/_____

Service Coordinator:_____ Date:_____/_____/_____

Other Team Member:_____ Date:_____/_____/_____

Other Team Member:_____ Date:_____/_____/_____

Other Team Member:_____ Date:_____/_____/_____

~For Interim IFSPs Only~

I have participated in the development of this Interim IFSP and agree to its implementation. I understand that an Interim IFSP 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/Guardian Signature:_____ Date:_____/_____/_____

Service Coordinator:_____ Date:_____/_____/_____