Name: _____

DOB: ___/___/_____

SC: _____

Individualized Family Service Plan (IFSP)

Annual IFSP Start Date*: ___/___/_____ ☐ Initial ☐ Interim ☐ Periodic ☐ Annual

Prior Notice Date °: ___/___/_____ Consent for Services Date °: ___/___/_____

Proposed Periodic Review*: ___/___/_____ Primary Language*: _____

Secondary Language: _____

Primary Family Contacts (family where child resides)

Parent/Guardian*: _____ Parent/Guardian: _____

Relationship*: _____ Relationship: _____

Email: _____ Email: _____

Mobile Phone: _____ Mobile Phone: _____

Work Phone: _____ ☐ Do Not Release Work Phone: _____ ☐ Do Not Release

Address*: _____ Primary Phone*: _____

City*: _____ Zip*: _____ ☐ Do Not Release Address or Phone

Alternate Family Contacts

Parent/Guardian*: _____ Parent/Guardian: _____

Relationship*: _____ Relationship: _____

Email: _____ Email: _____

Mobile Phone: _____ Mobile Phone: _____

Work Phone: _____ ☐ Do Not Release Work Phone: _____ ☐ Do Not Release

Address: _____ Primary Phone: _____

City: _____ Zip: _____ ☐ Do Not Release Address or Phone

Alternate Family Contacts

Parent/Guardian*: _____ Parent/Guardian: _____

Relationship*: _____ Relationship: _____

Email: _____ Email: _____

Mobile Phone: _____ Mobile Phone: _____

Work Phone: _____ ☐ Do Not Release Work Phone: _____ ☐ Do Not Release

Address: _____ Primary Phone: _____

City: _____ Zip: _____ ☐ Do Not Release Address or Phone

Utah Department of Health & Human Services
Family Health

Name: _____

DOB: ____/____/_____ *IFSP:* ____/____/_____

Child Care Provider (if applicable)

Name/Organization*: _____

Phone*: _____ Fax: _____

Street Address*: _____ Mailing Address: _____

City*: _____ Zip*: _____ City: _____ Zip: _____

Current Child Eligibility*

Current Eligibility Date*: ___/___/_____

☐ Standard Score (check qualifying domains)

☐ Gross Motor ☐ Receptive Language ☐ Adaptive
☐ Fine Motor ☐ Expressive Language
☐ Cognitive ☐ Social/Emotional

☐ Medical Diagnosis

Baby Watch Approved Qualified Diagnosis: _____

Medical Record Reviewed: ___/___/_____

☐ Informed Clinical Opinion

EI II Member: _____ Other Staff: _____

Our concern(s) about what the child is or is not doing is (are)*:

In our clinical opinion, the specific reason(s) that the child is eligible for early intervention is (are)*: