Name: _____

DOB: ___/___/_____

SC: _____

Individualized Family Service Plan (IFSP)

Annual IFSP Start Date*: ___/___/_____ ☐ Initial ☐ Interim ☑ Periodic ☐ Six-month ☐ Annual

Review Date*: ___/___/_____ Prior Notice: ___/___/_____

Consent for Services Date °: ___/___/_____

Proposed Annual 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
Baby Watch Early Intervention
Birth to Three Development

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)*:

UTAH DEPARTMENT OF HEALTH
Baby Watch Early Intervention
Birth to Three Development

Name: _____

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

Present Levels of Development

Health

Vision

Hearing

Gross Motor (strengths and needs related to body movement)

Name: _____

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

Fine Motor (strengths and needs related to using hands and fingers)

UTAH DEPARTMENT OF HEALTH
Baby Watch Early Intervention
Birth to Three Development

Name: _____

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

Present Levels of Development (cont...)

Cognitive (strengths and needs related to thinking and learning)

Receptive Communication (strengths and needs related to understanding words, gestures, and signs)

Expressive Communication (strengths and needs related to using words, gestures, and signs)

Social or Emotional (strengths and needs related to expressing and responding to feelings and interacting with others)

Adaptive (strengths and needs related to dressing, feeding, grooming, toileting, household responsibility)

Other Narrative

Name: _____

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

UTAH DEPARTMENT OF HEALTH
Baby Watch Early Intervention
Birth to Three Development

Name: _____

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

EI Outcomes

Num*	Date*	Outcome: What I want for my child and family*	Activities / Strategies (including who will be involved)	Review (most recent)
				Date: Rater: Rating: M PM NM D Comments:
				Date: Rater: Rating: M PM NM D Comments:
				Date: Rater: Rating: M PM NM D Comments:
				Date: Rater: Rating: M PM NM D Comments:
Review Rating Key:		*M = Met goal*	*PM = Partially Met*	*NM = Not Met* *D = Discontinued*

UTAH DEPARTMENT OF HEALTH
Baby Watch Early Intervention
Birth to Three Development

Name: ______________________________

DOB: ____/____/______ *IFSP:* ____/____/______

Services

Service Category / Provider	Frequency / Length	Duration	Intensity / Location	Transportation	Start / End
Add Date: ___/___/______					
Service Category* ____________	Frequency* ___ X ___		☐ Individual ☐ Group	☐ N/A ☐ Declined	Start ___/___/_____
Service Provider* ____________	Length* ___ mins	Duration* ___ mo.	Location* ____________	☐ Accepted ___ miles	End ___/___/_____
Add Date: ___/___/______					
Service Category* ____________	Frequency* ___ X ___		☐ Individual ☐ Group	☐ N/A ☐ Declined	Start ___/___/_____
Service Provider* ____________	Length* ___ mins	Duration* ___ mo.	Location* ____________	☐ Accepted ___ miles	End ___/___/_____
Add Date: ___/___/______					
Service Category* ____________	Frequency* ___ X ___		☐ Individual ☐ Group	☐ N/A ☐ Declined	Start ___/___/_____
Service Provider* ____________	Length* ___ mins	Duration* ___ mo.	Location* ____________	☐ Accepted ___ miles	End ___/___/_____
Add Date: ___/___/______					
Service Category* ____________	Frequency* ___ X ___		☐ Individual ☐ Group	☐ N/A ☐ Declined	Start ___/___/_____
Service Provider* ____________	Length* ___ mins	Duration* ___ mo.	Location* ____________	☐ Accepted ___ miles	End ___/___/_____
Add Date: ___/___/______					
Service Category* ____________	Frequency* ___ X ___		☐ Individual ☐ Group	☐ N/A ☐ Declined	Start ___/___/_____
Service Provider* ____________	Length* ___ mins	Duration* ___ mo.	Location* ____________	☐ Accepted ___ miles	End ___/___/_____

Name: _____

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

Justification Statements

Location Justification Statement

Service & Setting Requiring Justification: _____

Explain why the outcome cannot be met if the service is provided in the natural environment.*

Explain how services provided outside the natural environment will be generalized within activity settings and routines of the family.*

Describe a plan with time lines and supports necessary to allow the outcome to be satisfactorily achieved in a natural environment.*

Location Justification Statement

Service & Setting Requiring Justification: _____

Explain why the outcome cannot be met if the service is provided in the natural environment.*

Explain how services provided outside the natural environment will be generalized within activity settings and routines of the family.*

Describe a plan with time lines and supports necessary to allow the outcome to be satisfactorily achieved in a natural environment.*

Name: _____

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

Non-EI Services

(any services the child and family needs or is receiving through other sources, but that are neither required nor funded under Part C):

Non-EI Service Provider* _____

Note

Non-EI Service Provider* _____

Note

UTAH DEPARTMENT OF HEALTH
Baby Watch Early Intervention
Birth to Three Development

Name: _____

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

Signatures

I (parent or guardian) have participated in the development of this Individualized Family Service Plan and understand that I can accept or refuse any or all of the services identified in it. I understand that my consent for services may be withdrawn at any time.

I further understand that my signature below indicates that: (a) I have been fully informed of the services being proposed; (b) I have received the "Baby Watch Parents' Rights in Early Intervention" booklet and understand my parents rights in early intervention; and (c) I give consent to carry out our Individualized Family Service Plan as written.

_____ Signature of Parent or Guardian*	_____ Date* (mm/dd/yyyy)
_____ Signature of Parent or Guardian*	_____ Date* (mm/dd/yyyy)
_____ Service Coordinator*	_____ Date* (mm/dd/yyyy)
_____ Other Participant	_____ Date (mm/dd/yyyy)
_____ Other Participant	_____ Date (mm/dd/yyyy)

TRANSITION INFORMATION

The EI Provider provides services to eligible children from birth to age three. When your child is 27 months old, your early intervention program will talk with you about options that may be available depending on your child's abilities. Your three-year-old child may be eligible for special education preschool or you may consider other community preschool settings. If your child is not eligible for special education preschool, your service coordinator or service providers will help you identify community preschool setting options. A Transition Plan will be developed to help your family move from early intervention services to other services where appropriate.

Service Categories

- Special Instruction
- OT
- COTA
- PT
- PTA
- SLP
- Family Training
- Assistive Technology
- Audiology
- Health Services
- Medical
- Nursing
- Nutrition
- Psychological
- Respite Care
- Service Coordination
- Social Work
- Sign Language and Cued Speech

USDB Service Categories

- PIP BVI
- PIP BVI Toddler Group
- PIP DHH
- PIP DHH Deaf Toddler Group
- PIP Sign Language and Cued Speech
- USDB Communication Intervener
- USDB Deaf Mentor
- USDB Deaf/Blind
- USDB Orientation and Mobility