Ventura County

EARLY START PROGRAM

INDIVIDUAL FAMILY SERVICE PLAN (IFSP)
TRANSITION PLAN

This form is used to facilitate discussion of each child's unique needs and to review options for services that may be necessary and appropriate when the child turns age three.

Date:___________________ DOB: ____________________ UCI #: ____________________ SSN#: ______________________

Child's Name: ____ ☐ Male ☐ Female

Address: ____ Home Phone: _________________________________

Parent/Guardian/Surrogate: ______________________________________ Work Phone: _________________________________

Home Language: ____ School District: ______________________________

Service Coordinator/Agency: _____________________________________ Phone: ______________________________________

Transition booklet provided ☐ Yes ☐ No Date of Initial IFSP ______________________________

1. Current Early Start services, including provider: ____

____

____

2. Child's strengths: ____

____

____

3. Areas of concern related to transition and where skills are needed (home, community, daycare/preschool): ______________________

____

____

____

4. Family's plans for age three services/activities. Address any anticipated gaps in service (summer vacation, family trips): __________

____

____

____

5. Special health care needs (medications, equipment, vision and hearing): ____

____

____

6. Program options discussed: ____

____

____

 Child's Name______________________________

7. Eligibility for age three services:
Does the family want assessment for public school special education eligibility at age 3? ☐ Yes ☐ No

School District of Residence: ____________ Referral to be sent to district no later than: ____________

Potential Areas of Assessment: ____________

School District Contact Person: ____________ Phone: ____________ Email: ____________

Individualized Education Program (IEP) team meeting to be held by (no later than 3rd birthday): ____________

☐ Please invite my Early Start Service Coordinator to the IEP meeting.
Service Coordinator's Email: ____________

Additional follow-up steps (*if any. i.e. other data to be gathered, immunization records, medical records, appointments, etc.*): ____________

Does the family want assessment for Regional Center eligibility at age 3? ☐ Yes ☐ No

Areas of Assessment: ____________

Who will contact parent: ____________ Phone: ____________ By When: ____________

Individual Program Plan (IPP) meeting to be held by: ____________

Additional follow-up steps (*if any. i.e. other data to be gathered, immunization records, medical records, appointments, etc.*): ____________

8. Referral to Multidisciplinary, Multiagency Team Assessment (MMTA) ☐ Yes ☐ No

9. General notes: ____________

10. Agreement to proceed:

- ☐ I have participated in developing this IFSP Transition Plan
- ☐ I agree with the steps outlined in this plan
- ☐ I give my permission for the individuals and agencies indicated to carry out the plan with me
- ☐ I give permission for the schools and Regional Center to share information and assessments that are needed to develop a program for my child at age 3:

11. Signed:

Parent/Guardian/Surrogate Parent(s) ____________ Date ____________

Participant: ____________ Title/Agency: ____________

Participant: ____________ Title/Agency: ____________

Participant: ____________ Title/Agency: ____________

Family would like a referral to Rainbow Connection Family Resource Center	☐ Yes	☐ No