EARLY START SERVICES

INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP)

CHANGES OR ADDITIONS

Amends IFSP of: _____
(date)

IFSP TYPE:

- ☐ Periodic Review
- ☐ Information Change
- ☐ Parent Request
- ☐ Other: _____

STATUS:

- ☐ Continue IFSP
- ☐ Modify IFSP
- ☐ End IFSP

This IFSP meeting (date): _____

Projected Review: 6 months or before _____

Annual _____

Projected IFSP Exit _____

Translated IFSP needed? ☐ yes ☐ no Language _____

Service Coordinator _____ Agency _____ Phone _____

Child Social Security Number _____ Child Case Number, if applicable _____

IDENTIFYING INFORMATION

Child's name _____
First Middle Last

Birth date _____ Age _____ Gender _____

Home Language _____ Interpreter needed? ☐ yes ☐ no

Parent/Guardian _____

Street address _____

Mailing address _____

Home phone _____ Work phone _____ Message phone _____

CHANGE TO PLAN

(*check areas revised, added,or deleted and attach new pages*)

- A ☐ Identifying Information (*Record changes above*)
- B ☐ Summary of Services
- C ☐ Family Concerns, Priorities, Resources
- D ☐ Medical, Present Levels of Development
- E ☐ Outcomes and Services
- F ☐ Transition Plan
- G ☐ Other, specify _____

CHILD STATUS CHANGE

(*check those that apply*)

- ☐ No longer eligible
- ☐ Moved out of county to _____
- ☐ Agency withdrawal
- ☐ Parent withdrawal
- ☐ Whereabouts unknown
- ☐ Transition to _____
- ☐ Other, specify _____

Comments: _____

MODIFIED BY (*to include parent*):

Name/Title	Signature/or Other Verification of Authorization	Agency	Phone	Date
Name-Parent(s)	Signature/or Other Verification of Authorization		Phone	Date

cc: _____ _____

_____ _____