ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Arizona Early Intervention Program (AzEIP)

☑ IFSP Type:
☑ IFSP Date:

INDIVIDUALIZED FAMILY SERVICE PLAN
SERVICES NEEDED TO MAKE PROGRESS TOWARDS OUTCOMES (Addendum)

Child's Name *(First, M.I., Last)* _____ Date of Birth _____

Outcome No.	Early Intervention Service	*Intensity	Frequency		Service Setting	Method	Duration	
			No. of sessions	No. of minutes per session	H = Home C = Community O = Other *(If other, complete the justification below)*	TL = Team Lead JV = Joint Visits TC = Team Conferencing NTL = Non Team Lead	Planned Start Date	Planned End Date
	Service Coordination				☐H ☐C ☐O			
					☐H ☐C ☐O			
					☐H ☐C ☐O			
					☐H ☐C ☐O			
					☐H ☐C ☐O			
					☐H ☐C ☐O			
					☐H ☐C ☐O			

Select ONLY one Primary Service Setting: ☐H ☐C ☐O
(Primary Setting is the setting in which the infant or toddler receives the most hours of an early intervention service.)

***Intensity: I** = Individual **UN** = Multiple eligible children (2) **UP** = Multiple eligible children (3 or more)

JUSTIFICATION OF EARLY INTERVENTION OUTCOMES THAT CANNOT BE ACHIEVED SATISFACTORILY IN A NATURAL ENVIRONMENT

Service _____ Location of Service _____ Service Provider _____

If an early intervention service is not provided in the natural environment, what is the justification for the IFSP team's decision that outcomes cannot be achieved in the natural environment?

Explain how early intervention services will support the child's participation in routines and activities to meet the IFSP outcomes.

Explain the plan and timeline to move services into the natural environment.

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INDIVIDUALIZED FAMILY SERVICE PLAN
PAYMENT ARRANGEMENTS FOR SERVICES

Child's Name *(First, M.I., Last)* _____ Date of Birth _____

☐ Service Coordinator and family discussed use of family's public and/or private insurance:

☐ Public Insurance:

☐ AHCCCS ☐ CMDP ☐ IHS ☐ DDD/ALTCS ☐ Other (e.g., EPD/ALTCS): _____

Health Plan: _____

☐ Private Insurance Plan: _____

(Consent is required before billing public and private insurance)

Early Intervention Service *(no acronyms)*	**Discipline**	***Funding Source(s)** *(include all that apply)*

***Funding Source:**

1 = Medicaid (AHCCCS/CMDP)
2 = Private Insurance (PI)
3 = Arizona Early Intervention Program (AzEIP)
4 = Division of Developmental Disabilities (DDD)
5 = Arizona Long Term Care System (ALTCS)
6 = Arizona State Schools for the Deaf and the Blind (ASDB)

Other Services *(in place or needed)*

Services such as medical, recreational, religious, social and other child related services not required or funded under early intervention, that contribute to this plan.

- Resources your family has that are helpful in meeting the needs of your child/family (e.g., respite, as covered under ALTCS).
- Resources that you are interested in to help your family (e.g., WIC, health care, etc.).

Resource(s), Service(s), and Support(s)	**Check if needed**	**Payment Source**	**Steps to be Taken** *(Include person responsible and timeline)*
	☐		
	☐		
	☐		
	☐		
	☐		

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INDIVIDUALIZED FAMILY SERVICE PLAN
INFORMED CONSENT BY PARENT(S) FOR SERVICES

Child's Name *(First, M.I., Last)* _____ Date of Birth _____

I have participated in the development of this IFSP and understand that I can accept or refuse any or all of the services identified in the IFSP. I understand that my consent for services may be withdrawn at any time. Please initial and sign below.

_____ 1a. I agree with the proposed IFSP as written. I further understand that my signature below indicates that: (a) I have been fully informed of the services being proposed and the reason for the proposal of services; (b) my service coordinator explained my rights under this program; and (c) I give consent to carry out this IFSP as written.

_____ 1b. I do not agree with the proposed IFSP as written (Prior Written Notice form must be completed and given to the family). However, I do consent to the following services/frequency:

_____ 2. My service coordinator explained my rights under this program.
I ☐ Accept ☐ Decline a written copy of the AzEIP Family Rights Handbook.

_____ 3. I have received a copy of the AzEIP Family Survey (Annual or Transition/Exit IFSP).

_____ _____ _____ _____
Parent Signature Date Parent Signature Date

In addition to the release of this IFSP to team members, I give my consent for a copy of this IFSP to be sent to the individuals or agencies listed below.

Name of Individual/Agency *(e.g., pediatrician, Early Head Start program)*	**Purpose**

Parent Signature _____ Date _____

I understand that I have agreed to disclose my IFSP to the person/agency listed above and that person/agency may not disclose this IFSP to anyone else without my consent. This consent is valid for one year unless I revoke it at any time.

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INDIVIDUALIZED FAMILY SERVICE PLAN
IFSP TEAM

Child's Name *(First, M.I., Last)* _____ Date of Birth _____

The following team members participated in the development of this IFSP. Each individual understands the plan as it applies to their role in providing services. All team members understand that the IFSP must be reviewed at least every 6 months and can be revised at any time by the request of any team member, including the family. List team members, present or not, who contributed to the development of the IFSP.

IFSP TEAM MEMBERS				
Service Coordination	**Discipline/Role**	**Agency/Program**	**Phone No.**	**Initial if present**
Team Lead	**Discipline/Role**	**Agency/Program**	**Phone No.**	**Initial if present**
IFSP Team Member	**Discipline/Role**	**Agency/Program**	**Phone No.**	**Initial if present**
IFSP Team Member	**Discipline/Role**	**Agency/Program**	**Phone No.**	**Initial if present**
IFSP Team Member	**Discipline/Role**	**Agency/Program**	**Phone No.**	**Initial if present**

Core Team Members	Discipline/Role