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

This is the
INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP)

For _____ and Family

☐ Interim IFSP ☐ Initial IFSP ☐ Annual IFSP

Date: _____

Service Coordinator: _____

Team Lead: _____

Our Mission – Early intervention builds upon and provides supports and resources to assist family members and caregivers to enhance children's learning and development through everyday learning opportunities.

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

☑ IFSP Type:
☑ IFSP Date:

CHILD AND FAMILY

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

Gender: ☐ Female ☐ Male Child ID No.: _____ AzEIP Eligibility Date: _____

Service Coordinator's Name: _____ Agency/Program: _____

Phone No.: _____ Email Address: _____

With Whom the Child Resides

☐ Parent ☐ Family Member ☐ Foster Parent ☐ Guardian

Name *(First, M.I., Last)*: _____

Address *(No., Street, City, County, State, ZIP Code)*: Major cross streets or directions to the home:

_____ _____

Phone No.: _____ Email Address: _____

Language used by the parent/caregiver: _____ Interpreter needed: ☐ Yes ☐ No If yes, what language? _____

School District: _____ Date Child is 2.6: _____

Additional Caregiver/Address

☐ Parent ☐ Family Member ☐ Guardian

Name *(First, M.I., Last)*: _____

Address *(No., Street, City, County, State, ZIP Code)* ***If different than above***: Major cross streets or directions to the home:

_____ _____

Phone No.: _____ Email Address: _____

Language used by the parent/caregiver: _____ Interpreter needed: ☐ Yes ☐ No If yes, what language? _____

Health Information

Primary Care Provider (PCP): _____ Phone No.: _____

Date vision screening conducted *(Vision screening checklist)*: _____ Number of indicators or risk factors checked: _____

Comments, next step:

Date hearing screening conducted *(Hearing screening tracking form is NOT a hearing screening)*: _____

Results of OAE *(or other hearing screening)*: Left Ear _____ Right Ear _____

If a hearing screening has not been conducted within 6 months, strategies to obtain a screening must be included.

Comments, next step:

Please describe your child's current health status. Include diagnosis (if applicable), specialists involved, serious illnesses, seizures, hospitalizations, and medications taken regularly and how this may be impacting your child's development.

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

☑ IFSP Type:
☑ IFSP Date:

INDIVIDUALIZED FAMILY SERVICE PLAN
CHILD AND FAMILY ASSESSMENT

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

Summary of Child Development within Routines and Activities

This Child and Family Assessment will capture all areas of my child's development within the contexts of everyday routines and activities that are important to our family. We will discuss areas that we identify are going well and areas that are not going well, while discussing all areas of my child's development. I can follow along with my copy of the Child and Family Assessment Guide for Families.

☐ Communication ☐ Movement ☐ Thinking/Learning ☐ Social/Behavior ☐ Self-help ☐ Vision ☐ Hearing

Activity *(check one)*:

☐ Wake up	☐ Dressing	☐ Diapering/Toileting
☐ Mealtime/Snacks	☐ Outings	☐ Play
☐ Bath time	☐ Bedtime/Naps	☐ Other *(describe)*: _____

How is it going? *(check one for each question)*:

For you?	☐ Going well	☐ Some concerns	☐ A lot of concerns
For your child?	☐ Going well	☐ Some concerns	☐ A lot of concerns
For other caregivers?	☐ Going well	☐ Some concerns	☐ A lot of concerns

Comments/Details:

1. Who is involved in this activity?

2. What is happening now?

3. Is this an activity in which you would like to receive support from your early intervention team? ☐ Yes ☐ No
   If yes, what would it look like if it was going well?

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

☑ IFSP Type:
☑ IFSP Date:

INDIVIDUALIZED FAMILY SERVICE PLAN
CHILD AND FAMILY ASSESSMENT

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

Summary of Child Development within Routines and Activities

☐ Communication ☐ Movement ☐ Thinking/Learning ☐ Social/Behavior ☐ Self-help ☐ Vision ☐ Hearing

Activity *(check one)*:

☐ Wake up	☐ Dressing	☐ Diapering/Toileting
☐ Mealtime/Snacks	☐ Outings	☐ Play
☐ Bath time	☐ Bedtime/Naps	☐ Other *(describe)*: _____

How is it going? *(check one for each question)*:

For you?	☐ Going well	☐ Some concerns	☐ A lot of concerns
For your child?	☐ Going well	☐ Some concerns	☐ A lot of concerns
For other caregivers?	☐ Going well	☐ Some concerns	☐ A lot of concerns

Comments/Details:

1. Who is involved in this activity?

2. What is happening now?

3. Is this an activity in which you would like to receive support from your early intervention team? ☐ Yes ☐ No
   If yes, what would it look like if it was going well?

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

☑ IFSP Type:
☑ IFSP Date:

INDIVIDUALIZED FAMILY SERVICE PLAN
CHILD AND FAMILY ASSESSMENT

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

Summary of Child Development within Routines and Activities

☐ Communication ☐ Movement ☐ Thinking/Learning ☐ Social/Behavior ☐ Self-help ☐ Vision ☐ Hearing

Activity *(check one)*:

☐ Wake up	☐ Dressing	☐ Diapering/Toileting
☐ Mealtime/Snacks	☐ Outings	☐ Play
☐ Bath time	☐ Bedtime/Naps	☐ Other *(describe)*: _____

How is it going? *(check one for each question)*:

For you?	☐ Going well	☐ Some concerns	☐ A lot of concerns
For your child?	☐ Going well	☐ Some concerns	☐ A lot of concerns
For other caregivers?	☐ Going well	☐ Some concerns	☐ A lot of concerns

Comments/Details:

1. Who is involved in this activity?

2. What is happening now?

3. Is this an activity in which you would like to receive support from your early intervention team? ☐ Yes ☐ No
   If yes, what would it look like if it was going well?

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

☑ IFSP Type:
☑ IFSP Date:

INDIVIDUALIZED FAMILY SERVICE PLAN
CHILD AND FAMILY ASSESSMENT

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

Summary of Child Development within Routines and Activities

☐ Communication ☐ Movement ☐ Thinking/Learning ☐ Social/Behavior ☐ Self-help ☐ Vision ☐ Hearing

Activity *(check one)*:

☐ Wake up	☐ Dressing	☐ Diapering/Toileting
☐ Mealtime/Snacks	☐ Outings	☐ Play
☐ Bath time	☐ Bedtime/Naps	☐ Other *(describe)*: _____

How is it going? *(check one for each question)*:

For you?	☐ Going well	☐ Some concerns	☐ A lot of concerns
For your child?	☐ Going well	☐ Some concerns	☐ A lot of concerns
For other caregivers?	☐ Going well	☐ Some concerns	☐ A lot of concerns

Comments/Details:

1. Who is involved in this activity?

2. What is happening now?

3. Is this an activity in which you would like to receive support from your early intervention team? ☐ Yes ☐ No
   If yes, what would it look like if it was going well?

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

☑ IFSP Type:
☑ IFSP Date:

INDIVIDUALIZED FAMILY SERVICE PLAN
CHILD AND FAMILY ASSESSMENT

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

Natural Resources

List the people and resources that support your family *(e.g., friends, neighbors, extended family, neighborhood play groups, community activities, parks, social, church or other faith-based groups)*:

Areas of Interest

Check items your family would like more information about:

- ☐ Places where my child can play with other children in the community
- ☐ Childcare
- ☐ Clothing, food, etc.
- ☐ Housing Assistance
- ☐ Health care and/or health insurance for my child
- ☐ My child's diagnosis or disability
- ☐ Talking with other parents
- ☐ Parent support/ training/advocacy
- ☐ Other: _____
- ☐ Other: _____

Priorities

From the Summary of Routines and Activities and Areas of Interest, ask the family to identify which are the most important areas to address in the next 3-6 months. Include the resources that are in place, or could be put in place, to support the priority.

Priorities	Natural Resources

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

☑ IFSP Type:
☑ IFSP Date:

CHILD INDICATORS SUMMARY

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

I-TEAMS ID No.: _____ Date of Rating: _____ Rating Indicator: ☐ Entry ☐ Exit ☐ Review

Eligibility Categories: ☐ Developmental Delay ☐ Established Condition ☐ Informed Clinical Opinion

IFSP TEAM MEMBERS *(Includes anyone contributing to the rating process)*	**ROLES**

SOURCES OF SUPPORTING EVIDENCE	**DATES**

1. POSITIVE SOCIAL-EMOTIONAL SKILLS *(Including Social Relationships)*

- **Relating with adults**
- **Relating with other children**
- **For older children, following rules related to groups or interacting with others**

1a. To what extent does this child show age-appropriate functioning across a variety of settings and situations on this outcome?

Completely		**Sometimes**		**Emerging**		**Not Yet**
☐ 7	☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

1b. Describe skills or behaviors related to positive social-emotional skills (including positive social relationships).

Has the child made progress since the last rating? ☐ Yes ☐ No ☐ N/A

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

☑ IFSP Type:
☑ IFSP Date:

CHILD INDICATORS SUMMARY

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

2. ACQUIRING AND USING KNOWLEDGE AND SKILLS

- **Thinking, reasoning, remembering, and problem solving**
- **Understanding symbols and language**
- **Understanding the physical and social worlds**

2a. To what extent does this child show age-appropriate functioning across a variety of settings and situations on this outcome?

Completely		Sometimes		Emerging		Not Yet
☐ 7	☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

2b. Describe skills or behaviors related to acquiring and using knowledge and skills.

Has the child made progress since the last rating? ☐ Yes ☐ No ☐ N/A

3. TAKING APPROPRIATE ACTION TO MEET NEEDS

- **Taking care of basic needs** *(e.g. showing interest in eating, dressing, feeding, toileting, etc.)*
- **Getting from place to place (mobility) and using tools** *(e.g. forks, strings attached to objects)*
- **If older than 24 months, contributing to own health and safety** *(e.g. follows rules, assists with hand washing, avoids inedible objects)*

3a. To what extent does this child show age-appropriate functioning across a variety of settings and situations on this outcome?

Completely		Sometimes		Emerging		Not Yet
☐ 7	☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

3b. Describe skills or behaviors related to taking appropriate action to meet needs.

Has the child made progress since the last rating? ☐ Yes ☐ No ☐ N/A

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

☑ IFSP Type:
☑ IFSP Date:

INDIVIDUALIZED FAMILY SERVICE PLAN
OUTCOME FOR CHILD AND FAMILY

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

Outcome Number: _____

Priority – What priority will this outcome address? *(Refer to **Priorities** from the **Child and Family Assessment**)*

Outcome – What will it look like when things are going well? *(Refer to **Summary of Routines and Activities** and/or **Areas of Interest**)*

Strategies – What specific steps and Natural Resources will help us meet this outcome? *(Include people and ideas that will help with this activity or routine – refer to **Natural Resources**)*

Outcome Status

At each review, as a team, we review this outcome and document the status. The IFSP team has decided to:

☐ Complete ☐ Continue ☐ Discontinue ☐ Revise Date: _____

Describe:

☐ Complete ☐ Continue ☐ Discontinue ☐ Revise Date: _____

Describe:

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

☑ IFSP Type:
☑ IFSP Date:

INDIVIDUALIZED FAMILY SERVICE PLAN
OUTCOME FOR CHILD AND FAMILY

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

Outcome Number: _____

Priority – What priority will this outcome address? *(Refer to **Priorities** from the **Child and Family Assessment**)*

Outcome – What will it look like when things are going well? *(Refer to **Summary of Routines and Activities** and/or **Areas of Interest**)*

Strategies – What specific steps and Natural Resources will help us meet this outcome? *(Include people and ideas that will help with this activity or routine – refer to **Natural Resources**)*

Outcome Status

At each review, as a team, we review this outcome and document the status. The IFSP team has decided to:

☐ Complete ☐ Continue ☐ Discontinue ☐ Revise Date: _____

Describe:

☐ Complete ☐ Continue ☐ Discontinue ☐ Revise Date: _____

Describe:

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

☑ IFSP Type:
☑ IFSP Date:

INDIVIDUALIZED FAMILY SERVICE PLAN
OUTCOME FOR CHILD AND FAMILY

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

Outcome Number: _____

Priority – What priority will this outcome address? *(Refer to **Priorities** from the **Child and Family Assessment**)*

Outcome – What will it look like when things are going well? *(Refer to **Summary of Routines and Activities** and/or **Areas of Interest**)*

Strategies – What specific steps and Natural Resources will help us meet this outcome? *(Include people and ideas that will help with this activity or routine – refer to **Natural Resources**)*

Outcome Status

At each review, as a team, we review this outcome and document the status. The IFSP team has decided to:

☐ Complete ☐ Continue ☐ Discontinue ☐ Revise Date: _____

Describe:

☐ Complete ☐ Continue ☐ Discontinue ☐ Revise Date: _____

Describe:

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

☑ IFSP Type:
☑ IFSP Date:

INDIVIDUALIZED FAMILY SERVICE PLAN
OUTCOME FOR CHILD AND FAMILY

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

Outcome Number: _____

Priority – What priority will this outcome address? *(Refer to **Priorities** from the **Child and Family Assessment**)*

Outcome – What will it look like when things are going well? *(Refer to **Summary of Routines and Activities** and/or **Areas of Interest**)*

Strategies – What specific steps and Natural Resources will help us meet this outcome? *(Include people and ideas that will help with this activity or routine – refer to **Natural Resources**)*

Outcome Status

At each review, as a team, we review this outcome and document the status. The IFSP team has decided to:

☐ Complete ☐ Continue ☐ Discontinue ☐ Revise Date: _____

Describe:

☐ Complete ☐ Continue ☐ Discontinue ☐ Revise Date: _____

Describe:

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

☑ IFSP Type:
☑ IFSP Date:

INDIVIDUALIZED FAMILY SERVICE PLAN TRANSITION

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

School District: _____ AzEIP Eligibility Date: _____

Date Transition Planning Meeting Due *(Refer to AzEIP Transition Timeline)*: _____ Date Transition Planning Meeting Completed: _____

Date Transition Conference Due *(Refer to AzEIP Transition Timeline)*: _____ Date Transition Conference Completed: _____

By initialing below, I acknowledge that the Transition Planning Meeting steps needed to support my child and family's transition from early intervention have been discussed:

_____ My Service Coordinator explained that the purpose of the Transition Planning Meeting is to discuss and document all of the necessary steps to ensure my child and family has a smooth transition out of early intervention services at age 3.

_____ A vision screening checklist must have been completed within the past 12 months;
Date of my child's last vision screening: _____

_____ A hearing screening must have been completed within the past 12 months;
Date of my child's last hearing screening: _____

_____ If a hearing screening has not been completed within the past 12 months,
we will obtain one no later than: _____

_____ I received information from my Service Coordinator to support me in obtaining a hearing screening for my child.

My Service Coordinator and team discussed with me the services and supports that may be available to my child and family upon transition out of early intervention services, including tentative timelines, as documented below:

_____ Preschool Options *(i.e., developmental preschool, private or community preschools, Head Start)*: _____

_____

_____ Community Resources *(i.e., home visiting programs, parent support groups or trainings)*: _____

_____

_____ Options available through my child's health insurance and/or other public agencies: _____

_____

_____ My Service Coordinator discussed the need to provide informed consent before sharing information about my child and family with any parties involved with my child's transition process.

My family has the following questions, concerns and priorities regarding transitioning my child from early intervention services:

As a result of these questions, concerns and priorities, IFSP Outcome(s) were specifically developed to support my child and family. Refer to IFSP Outcome(s) number _____.

PEA NOTIFICATION

_____ I understand that my Service Coordinator will provide a notification including demographic information about my child and family to my local school district and the Arizona Department of Education (based on the AzEIP Transition Timeline), unless I opt out of this notification by signing the opt-out portion of the PEA Notification Referral form.

Date PEA Notification sent: _____ Date parent opted out of Notification: _____

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

☑ IFSP Type:
☑ IFSP Date:

INDIVIDUALIZED FAMILY SERVICE PLAN TRANSITION

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

TRANSITION CONFERENCE PLANNING

_____ **I agree** to have a Transition Conference and understand my Service Coordinator must send an invitation to participate to a representative(s) from my local school district. Additionally, I would like the following people and/or programs invited to the Transition Conference:

1. _____
2. _____
3. _____
4. _____

_____ **I do not agree** to have a Transition Conference and understand my Service Coordinator will not coordinate a meeting with my local school district.

Responsible Party Initials	**Additional Activities Prior to Exit:**	**Date Achieved**
	Child Exit Indicator summary completed.	
	My Service Coordinator and team provided me with an AzEIP Family Survey, and explained the importance of completing it.	
	My Service Coordinator provided me a copy of my child's record before exiting early intervention.	
	If my child is eligible for an AHCCCS Health Plan, my child will be referred to AHCCCS for continuum of services after the age of 3.	
	If my child is eligible for DDD, when my child turns 3 my family plans to: ☐ Remain enrolled in DDD ☐ Withdraw from DDD	
	If my child is not currently eligible for DDD, my Service Coordinator has discussed the DDD eligibility requirements, and my Service Coordinator and family plan to: ☐ Complete the DDD application process at this time ☐ Not complete the DDD application process at this time	
	Other:	
	Other:	
	Other:	

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

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

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

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

☑ IFSP Type:
☑ IFSP Date:

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)*
	☐		
	☐		
	☐		
	☐		
	☐		

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

☑ IFSP Type:
☑ IFSP Date:

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.

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

☑ IFSP Type:
☑ IFSP Date:

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