Arizona Department of Economic Security
Arizona Early Intervention Program (AzEIP)
Division of Developmental Disabilities

IFSP Addendum and Planning Meeting Review Packet

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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	Method		Duration	
			No. of sessions	No. of minutes per session	H = Home C = Community O = Other *(If other, complete the justification below)*	TBEIS Identifier	Primary Method	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 Complete Care ☐ CHP ☐ AIHP ☐ DDD/ALTCS ☐ EPD/ALTCS ☐ Tricare

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)
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

Planning Meeting Review

Member Name (Last, First, M.I.) ______ AHCCCS ID ______

Support Coordinator ______ Date ______

The member's eligibility is: ☐ ALTCS ☐ Targeted ☐ DDD (state funded)

This document is an extension of the PCSP, which is a living document and to be utilized during 90-day planning review meetings. The member or responsible person may request the full PCSP to be updated at any time.

I. Meeting Information

Attendee Name	Invited	Attended	Provided Input (e.g., by phone, email)
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	

Review Type:

☐ 1st 90 Day ☐ 2nd 90 Day ☐ 3rd 90 Day

☐ 180-day *(in alternative residential setting, over age 12 & no BH involvement)*

☐ 10-Day Change in Community Setting ☐ 10-Day Post-Discharge

☐ 30-day post placement ☐ Other/Special Teaming *(Specify)* ______

Meeting Location Type:

☐ Member Home ☐ Community: ______

☐ Virtual ☐ Alternative Service Setting: ______

If virtual, did the responsible person request this option, and is the member eligible for a virtual meeting? ☐ Yes ☐ No

If no explain: ______

Address (No, Street, City, State, Zip Code): ______

The following options are available ONLY for DD-Only, Targeted, or LTC/Acute Care Only:

☐ Phone ☐ Letter

See page 38 for EOE/ADA disclosures

Describe observations and interactions with the member. (e.g., appearance of the member, how the member engaged in the review meeting, what was occurring during the meeting, environment). **The member must be present for the meeting.**

Comments:

II. Plan Review And Team Feedback

A. What changes have occurred in your life since we last met?

B. Are you satisfied with the current living situation, or would you like to explore other options?

Document discussion and outcome:

C. Are you receiving the assessed services regularly? ☐ Yes ☐ No

If no, please tell me about your experience with the supports and services in place and any gaps or barriers.

D. Have there been any changes to the indirect services (school, BH, etc.)? ☐ Yes ☐ No

If yes, what recent updates or changes should we know about?

E. In what ways are the long-term care services meeting - or not meeting - your needs?

F. What has your experience been with your current providers?

III. Medical Supports And Information (Document all changes in the Discussion section.)

Have you experienced any changes to your medical condition(s)? ☐ Yes ☐ No
Document discussion and any changes if applicable:

Have there been any medical or dental appointments since the last meeting? ☐ Yes ☐ No
Document discussion and any changes if applicable:

Have there been any medication changes (*including psychotropic medications*) since the last meeting? ☐ Yes ☐ No
Document discussion and any changes if applicable:

Have you been hospitalized, including Emergency Room visits, in the last 90 days for a medical issue/concern? ☐ Yes ☐ No
Document discussion and any changes if applicable:

Have there been any changes to your behavioral health needs and/or services? ☐ Yes ☐ No
Document discussion and any changes if applicable:

Have there been any behavioral incidents since the last meeting that involved police, crisis calls, or incident reports? ☐ Yes ☐ No
Document discussion and any changes if applicable:

Does the member need a behavior plan? If yes, describe the plan to develop and implement a Behavior Plan and include action items in Section IX? ☐ Yes ☐ No ☐ NA
Document discussion and any changes if applicable:

If you have a Behavior Plan, is it current and effective? ☐ Yes ☐ No ☐ NA
Document discussion and any changes if applicable:

IV. Individual Goals And Outcomes

Review and write each goal and outcome from the current plan. Indicate if any goals were added, revised or discontinued.

Goal #:

Outcome:

Progress *(Include progress updates from all planning team members and action items)*:

Changes: ☐ No Changes Needed ☐ Revised ☐ New ☐ Discontinued

If new, complete the following:

Where are they now (at the time of this plan, including any barriers impacting/preventing the member from completing or achieving their goal)?

What actions will the team take to support the member in achieving/reaching their goal, including re-assessing goals, interventions, strategies for goal success, etc.? The support coordinator should document member's active participation in goal progress or achievement.

A.

B.

C.

Who will do what:	When?
A.	
B.	
C.	

Goal #:

Outcome:

Progress *(Include progress updates from all planning team members and action items)*:

Changes: ☐ No Changes Needed ☐ Revised ☐ New ☐ Discontinued

If new, complete the following:

Where are they now (at the time of this plan, including any barriers impacting/preventing the member from completing or achieving their goal)?

What actions will the team take to support the member in achieving/reaching their goal, including re-assessing goals, interventions, strategies for goal success, etc.? The support coordinator should document member's active participation in goal progress or achievement.

A.

B.

C.

Who will do what:	When?
A.	
B.	
C.	

Goal #:

Outcome:

Progress *(Include progress updates from all planning team members and action items)*:

Changes: ☐ No Changes Needed ☐ Revised ☐ New ☐ Discontinued

If new, complete the following:

Where are they now (at the time of this plan, including any barriers impacting/preventing the member from completing or achieving their goal)?

What actions will the team take to support the member in achieving/reaching their goal, including re-assessing goals, interventions, strategies for goal success, etc.? The support coordinator should document member's active participation in goal progress or achievement.

A.

B.

C.

Who will do what:	When?
A.	
B.	
C.	

Goal #:

Outcome:

Progress *(Include progress updates from all planning team members and action items)*:

Changes: ☐ No Changes Needed ☐ Revised ☐ New ☐ Discontinued

If new, complete the following:

Where are they now (at the time of this plan, including any barriers impacting/preventing the member from completing or achieving their goal)?

What actions will the team take to support the member in achieving/reaching their goal, including re-assessing goals, interventions, strategies for goal success, etc.? The support coordinator should document member's active participation in goal progress or achievement.

A.

B.

C.

Who will do what:	When?
A.	
B.	
C.	

Goal #:

Outcome:

Progress *(Include progress updates from all planning team members and action items)*:

Changes: ☐ No Changes Needed ☐ Revised ☐ New ☐ Discontinued

If new, complete the following:

Where are they now (at the time of this plan, including any barriers impacting/preventing the member from completing or achieving their goal)?

What actions will the team take to support the member in achieving/reaching their goal, including re-assessing goals, interventions, strategies for goal success, etc.? The support coordinator should document member's active participation in goal progress or achievement.

A.

B.

C.

Who will do what:	When?
A.	
B.	
C.	

Goal #:

Outcome:

Progress *(Include progress updates from all planning team members and action items)*:

Changes: ☐ No Changes Needed ☐ Revised ☐ New ☐ Discontinued

If new, complete the following:

Where are they now (at the time of this plan, including any barriers impacting/preventing the member from completing or achieving their goal)?

What actions will the team take to support the member in achieving/reaching their goal, including re-assessing goals, interventions, strategies for goal success, etc.? The support coordinator should document member's active participation in goal progress or achievement.

A.

B.

C.

Who will do what:	When?
A.	
B.	
C.	

Goal #:

Outcome:

Progress *(Include progress updates from all planning team members and action items)*:

Changes: ☐ No Changes Needed ☐ Revised ☐ New ☐ Discontinued

If new, complete the following:

Where are they now (at the time of this plan, including any barriers impacting/preventing the member from completing or achieving their goal)?

What actions will the team take to support the member in achieving/reaching their goal, including re-assessing goals, interventions, strategies for goal success, etc.? The support coordinator should document member's active participation in goal progress or achievement.

A.

B.

C.

Who will do what:	When?
A.	
B.	
C.	

Goal #:

Outcome:

Progress *(Include progress updates from all planning team members and action items)*:

Changes: ☐ No Changes Needed ☐ Revised ☐ New ☐ Discontinued

If new, complete the following:

Where are they now (at the time of this plan, including any barriers impacting/preventing the member from completing or achieving their goal)?

What actions will the team take to support the member in achieving/reaching their goal, including re-assessing goals, interventions, strategies for goal success, etc.? The support coordinator should document member's active participation in goal progress or achievement.

A.

B.

C.

Who will do what:	When?
A.	
B.	
C.	

Goal #:

Outcome:

Progress *(Include progress updates from all planning team members and action items)*:

Changes: ☐ No Changes Needed ☐ Revised ☐ New ☐ Discontinued

If new, complete the following:

Where are they now (at the time of this plan, including any barriers impacting/preventing the member from completing or achieving their goal)?

What actions will the team take to support the member in achieving/reaching their goal, including re-assessing goals, interventions, strategies for goal success, etc.? The support coordinator should document member's active participation in goal progress or achievement.

A.

B.

C.

Who will do what:	When?
A.	
B.	
C.	

Goal #:

Outcome:

Progress *(Include progress updates from all planning team members and action items)*:

Changes: ☐ No Changes Needed ☐ Revised ☐ New ☐ Discontinued

If new, complete the following:

Where are they now (at the time of this plan, including any barriers impacting/preventing the member from completing or achieving their goal)?

What actions will the team take to support the member in achieving/reaching their goal, including re-assessing goals, interventions, strategies for goal success, etc.? The support coordinator should document member's active participation in goal progress or achievement.

A.

B.

C.

Who will do what:	When?
A.	
B.	
C.	

Goal #:

Outcome:

Progress *(Include progress updates from all planning team members and action items)*:

Changes: ☐ No Changes Needed ☐ Revised ☐ New ☐ Discontinued

If new, complete the following:

Where are they now (at the time of this plan, including any barriers impacting/preventing the member from completing or achieving their goal)?

What actions will the team take to support the member in achieving/reaching their goal, including re-assessing goals, interventions, strategies for goal success, etc.? The support coordinator should document member's active participation in goal progress or achievement.

A.

B.

C.

Who will do what:	When?
A.	
B.	
C.	

Goal #:

Outcome:

Progress *(Include progress updates from all planning team members and action items)*:

Changes: ☐ No Changes Needed ☐ Revised ☐ New ☐ Discontinued

If new, complete the following:

Where are they now (at the time of this plan, including any barriers impacting/preventing the member from completing or achieving their goal)?

What actions will the team take to support the member in achieving/reaching their goal, including re-assessing goals, interventions, strategies for goal success, etc.? The support coordinator should document member's active participation in goal progress or achievement.

A.

B.

C.

Who will do what:	When?
A.	
B.	
C.	

Goal #:

Outcome:

Progress *(Include progress updates from all planning team members and action items)*:

Changes: ☐ No Changes Needed ☐ Revised ☐ New ☐ Discontinued

If new, complete the following:

Where are they now (at the time of this plan, including any barriers impacting/preventing the member from completing or achieving their goal)?

What actions will the team take to support the member in achieving/reaching their goal, including re-assessing goals, interventions, strategies for goal success, etc.? The support coordinator should document member's active participation in goal progress or achievement.

A.

B.

C.

Who will do what:	When?
A.	
B.	
C.	

Goal #:

Outcome:

Progress *(Include progress updates from all planning team members and action items)*:

Changes: ☐ No Changes Needed ☐ Revised ☐ New ☐ Discontinued

If new, complete the following:

Where are they now (at the time of this plan, including any barriers impacting/preventing the member from completing or achieving their goal)?

What actions will the team take to support the member in achieving/reaching their goal, including re-assessing goals, interventions, strategies for goal success, etc.? The support coordinator should document member's active participation in goal progress or achievement.

A.

B.

C.

Who will do what:	When?
A.	
B.	
C.	

Goal #:

Outcome:

Progress *(Include progress updates from all planning team members and action items)*:

Changes: ☐ No Changes Needed ☐ Revised ☐ New ☐ Discontinued

If new, complete the following:

Where are they now (at the time of this plan, including any barriers impacting/preventing the member from completing or achieving their goal)?

What actions will the team take to support the member in achieving/reaching their goal, including re-assessing goals, interventions, strategies for goal success, etc.? The support coordinator should document member's active participation in goal progress or achievement.

A.

B.

C.

Who will do what:	When?
A.	
B.	
C.	

V. Current Services Authorized

☐ Check here if the member does not have any services.

Service & Provider	Service Frequency In Place Prior To This Assessment	Service Frequency Currently Assessed	Service Change	Start/End Date	Member/HCDM
			☐ None ☐ New ☐ Increase ☐ Reduce ☐ Terminate ☐ Suspend ☐ Retroactive		☐ Agree ☐ Disagree
			☐ None ☐ New ☐ Increase ☐ Reduce ☐ Terminate ☐ Suspend ☐ Retroactive		☐ Agree ☐ Disagree
			☐ None ☐ New ☐ Increase ☐ Reduce ☐ Terminate ☐ Suspend ☐ Retroactive		☐ Agree ☐ Disagree
			☐ None ☐ New ☐ Increase ☐ Reduce ☐ Terminate ☐ Suspend ☐ Retroactive		☐ Agree ☐ Disagree
			☐ None ☐ New ☐ Increase ☐ Reduce ☐ Terminate ☐ Suspend ☐ Retroactive		☐ Agree ☐ Disagree
			☐ None ☐ New ☐ Increase ☐ Reduce ☐ Terminate ☐ Suspend ☐ Retroactive		☐ Agree ☐ Disagree

Service & Provider	Service Frequency In Place Prior To This Assessment	Service Frequency Currently Assessed	Service Change	Start/End Date	Member/HCDM
			☐ None ☐ New ☐ Increase ☐ Reduce ☐ Terminate ☐ Suspend ☐ Retroactive		☐ Agree ☐ Disagree
			☐ None ☐ New ☐ Increase ☐ Reduce ☐ Terminate ☐ Suspend ☐ Retroactive		☐ Agree ☐ Disagree
			☐ None ☐ New ☐ Increase ☐ Reduce ☐ Terminate ☐ Suspend ☐ Retroactive		☐ Agree ☐ Disagree
			☐ None ☐ New ☐ Increase ☐ Reduce ☐ Terminate ☐ Suspend ☐ Retroactive		☐ Agree ☐ Disagree
			☐ None ☐ New ☐ Increase ☐ Reduce ☐ Terminate ☐ Suspend ☐ Retroactive		☐ Agree ☐ Disagree
			☐ None ☐ New ☐ Increase ☐ Reduce ☐ Terminate ☐ Suspend ☐ Retroactive		☐ Agree ☐ Disagree
			☐ None ☐ New ☐ Increase ☐ Reduce ☐ Terminate ☐ Suspend ☐ Retroactive		☐ Agree ☐ Disagree

Service & Provider	Service Frequency In Place Prior To This Assessment	Service Frequency Currently Assessed	Service Change	Start/End Date	Member/HCDM
			☐ None ☐ New ☐ Increase ☐ Reduce ☐ Terminate ☐ Suspend ☐ Retroactive		☐ Agree ☐ Disagree
			☐ None ☐ New ☐ Increase ☐ Reduce ☐ Terminate ☐ Suspend ☐ Retroactive		☐ Agree ☐ Disagree
			☐ None ☐ New ☐ Increase ☐ Reduce ☐ Terminate ☐ Suspend ☐ Retroactive		☐ Agree ☐ Disagree
			☐ None ☐ New ☐ Increase ☐ Reduce ☐ Terminate ☐ Suspend ☐ Retroactive		☐ Agree ☐ Disagree
			☐ None ☐ New ☐ Increase ☐ Reduce ☐ Terminate ☐ Suspend ☐ Retroactive		☐ Agree ☐ Disagree
			☐ None ☐ New ☐ Increase ☐ Reduce ☐ Terminate ☐ Suspend ☐ Retroactive		☐ Agree ☐ Disagree
			☐ None ☐ New ☐ Increase ☐ Reduce ☐ Terminate ☐ Suspend ☐ Retroactive		☐ Agree ☐ Disagree

Was the Home and Community Based Service Needs Tool reviewed? ☐ Yes ☐ No ☐ NA

Describe any changes made, the services and provider options discussed, and if updated service assessment tools have been completed:

VI. Service Model Selected

Have any changes been made to the service model selected? ☐ Yes ☐ No ☐ N/A

If yes, what service model was selected?

☐ Traditional ☐ Agency with Choice ☐ Independent Provider (DDD)

☐ Parents as Paid Caregiver ☐ Spousal Attendant Care ☐ N/A

VII. Risks

Are there any new risks or changes to the existing identified risks? ☐ Yes ☐ No

Date New Risk Identified _____

For any new risks describe the changes:

What is the risk?

Describe the risk. What does it look like for the Member? Frequency? Location? Duration?

Contributing Factors:

What is currently working to prevent the risk/how is risk being effectively managed? (Interventions that are working and not working?

VIII. Member Rights Restrictions
(Only update this section if there is an existing, new or modified member rights restriction that has been approved through the Program Review Committee)

Describe any existing member rights restrictions.

Discuss if the existing member rights restriction is still necessary or can be terminated.

Describe any new or modified member’s rights restrictions that have been approved through PRC since the last meeting:

IX. Action Plan

Documentation must reflect the individuals responsible for monitoring the PCSP and provide updates on action items from the previous PCSP or Planning Meeting Review. Action plan items should focus on measurable steps that will need to be taken to reach desired outcomes in the member's life. These items may be related to a member's goals or other areas that need to be addressed and followed up on.

No.	Action To Be Taken	Person Responsible	Due Date (Target)	Follow-Up Date	Date Completed	Comments

X. Next Meeting Information

Next Meeting Due Date _____

Next Meeting Scheduled Date _____ **Time** _____

☐ Annual ☐ 1st 90-Day ☐ 2nd 90-Day ☐ 3rd 90-Day

☐ 180-day (in alternative residential setting, over age 12 & no BH involvement)

☐ Other/Special Teaming *(Specify)* _____

Type of Meeting: ☐ Virtual ☐ In-Person

If virtual, did the responsible person request this option, and is the member eligible for virtual meetings *(e.g., not receiving services through the PPCG, Spouse, or Independent Provider service model)*?

☐ Yes ☐ No If no, explain: _____

The following options are ONLY available for DD-Only, Targeted, or LTC/Acute Care Only:

☐ Phone ☐ Letter

If in person, specify the address and type of setting:

Address _____

Type of Setting:

☐ Member Home ☐ Community Setting _____

☐ Alternative Service Setting: _____

XI. Consent/Signature

Documentation must show that this review of the PCSP is finalized and agreed to, with the informed consent of the member in writing, and signed by all individuals and providers responsible for its implementation. An electronic signature in lieu of a wet signature is an acceptable method for obtaining consent and/or acknowledgment. My providers must receive a copy of the portions of the plan that explain how I want my services delivered and any restrictions agreed to by the PCSP team. My Support Coordinator has provided me with information about fraud, waste, and abuse, including how to report abuse, neglect, exploitation, and other critical incidents.

This plan has been reviewed with me by my Support Coordinator. My Support Coordinator discussed service options available to me, including information that helped inform the choices selected, decisions made, and reflected in this document. I know what services I will be getting and how often. All changes in the services I was getting have been explained to me. I have marked my agreement and/or disagreement with each service authorized in this plan. I know that any reductions, terminations, or suspensions (stopping for a set time frame) of my current services will begin no earlier than 10 days from the date of this plan. I know that I can ask for this to be sooner.

If I do not agree with some or all of the services that have been authorized in this plan, I have noted that in this plan. I know that my Support Coordinator will send me a letter that tells me why the service(s) I asked for was denied, reduced, suspended, or terminated. The letter will tell me how to appeal the decision that has been made about my services. The letter will also tell me how I can receive continued services.

My Support Coordinator has told me how the appeal process works. I know how I can appeal service changes I do not agree with. I know that I can change my mind later about the services I agree with today. I know that if I change my mind before the changes go into effect, I will get a letter that tells me the reason my services have changed. The letter will also tell me about my appeal rights, including how to receive continued services.

I know that I can ask for another PCSP meeting to go over my needs and any changes to this plan that are needed.

I can contact my Support Coordinator _____ at _____.

I also know that I can contact my Support Coordinator at any time to discuss questions, issues, and/or concerns that I may have regarding my services and/or related to fraud, waste, and abuse.

My Support Coordinator will contact me within 3 working days. Once I have talked with my Support Coordinator, he/she will give me a decision about that request within 14 days. If my Support Coordinator is not able to make a decision about my request within 14 days, s/he will send me a letter to let me know more time is needed to make a decision.

Member's Signature _____ Date _____

Responsible Person's Signature _____ Date _____

Second Responsible Person's Signature (when there is one) _____ Date _____

Support Coordinator's Signature _____ Date _____

ARIZONA DEPARTMENT OF ECONOMIC SECURITY

Katie Hobbs
Governor

Michael Wisehart
Director

Individualized Family Service Plan (IFSP) Meeting Notification

Date: _____

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

Date of Birth: _____ I-TEAMS ID: _____

This serves as your written notification for the Individualized Family Service Plan (IFSP) meeting that has been scheduled for the child above.

Meeting Date: _____ Time: _____ Parent requests the meeting be held: ☐ In Person ☐ Virtually

Address and/or Meeting Link:

The purpose of this IFSP meeting is to *(select all that apply)*:

☐ Develop the Select _____ IFSP to create child and family outcomes and identify early intervention supports and services.

☐ Review and revise the IFSP *(periodic review/addendum)*.

☐ Develop or update the transition plan within the IFSP by conducting an:

- ☐ IFSP Transition Planning Meeting
- ☐ IFSP Transition Conference
- ☐ Combined IFSP Transition Planning Meeting/Transition Conference

During the meeting participants will use all of the information available, including child and family routines and activities, family resources, priorities, concerns and interests, evaluation reports, progress notes, and appropriate medical and health records, to develop or update the IFSP.

As the parent(s) of a child who is involved with AzEIP, you have protections under the Individuals with Disabilities Education Act (IDEA). These protections are found in the Child and Family Rights in the Arizona Early Intervention Program (AzEIP) booklet which can be accessed through this link or QR code.

If you have any questions or are unable to attend the scheduled meeting, please contact:

Service Providing Agency: Select Type _____

AzEIP Service Coordinator: _____

Phone Number: _____ Email Address: _____

See page 2 for EOE/ADA disclosures

Participants Invited	
Name	**Role**
	Parent
	Parent
	AzEIP Service Coordinator
	IFSP Team Member Select Type
	IFSP Team Member Select Type
	IFSP Team Member Select Type
	School District/Public Education Agency (PEA) Representative
	Head Start Representative
	Community Preschool Representative
	Department of Child Safety (DCS) Representative
	Other:
	Other: