

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		Duration	
			No. of sessions	No. of minutes per session		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
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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.

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 <i>(no acronyms)</i>	Discipline	*Funding Source(s) <i>(include all that apply)</i>

***Funding Source:**

1 = Medicaid (AHCCCS)

4 = Division of Developmental Disabilities (DDD)

2 = Private Insurance (PI)

5 = Arizona Long Term Care System (ALTCS)

3 = Arizona Early Intervention Program (AzEIP)

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 <i>(Include person responsible and timeline)</i>

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 (<i>e.g., pediatrician, Early Head Start program</i>)	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.

