

Kids Kare main phone number
Baby Watch Early Intervention

Child Name*:
DOB:
IFSP Date:

Services

Service* or Child Class*

Service Category (choose one)*:

<input type="checkbox"/> Special Instruction	<input type="checkbox"/> Audiology Health Services	<input type="checkbox"/> Service Coordination	<input type="checkbox"/> PIP-DHH	Communication Intervener
<input type="checkbox"/> OT	<input type="checkbox"/> Medical	<input type="checkbox"/> Social Work	<input type="checkbox"/> PIP-DHH Deaf Toddler Group	<input type="checkbox"/> USDB Deaf/Blind
<input type="checkbox"/> PT	<input type="checkbox"/> Nursing	<input type="checkbox"/> Other EI Services	<input type="checkbox"/> PIP Sign Language and Cued Language	<input type="checkbox"/> USDB Deaf Mentor
<input type="checkbox"/> SLP	<input type="checkbox"/> Nutrition	<input type="checkbox"/> PIP-BVI	<input type="checkbox"/> USDB	<input type="checkbox"/> USDB orientation and Mobility
<input type="checkbox"/> Family Training	<input type="checkbox"/> Psychological	<input type="checkbox"/> PIP BVI		
<input type="checkbox"/> Assistive Technology		<input type="checkbox"/> Toddler Group		

Intensity*: Individual Group

Start Date*: _____ End Date: _____

Frequency*: _____ x Week Month Year

Length*: _____ min

Duration*: _____ months

Location*: Home Community Other

Service Provider*:

Transportation*: N/A Declined Accepted: # of miles _____ round trip

Justification Statement*:

Explain why the outcome cannot be met if the service is provided in the natural environment.

Explain how services provided in this location may be generalized within activity settings and routines of the family.

Describe a plan with timelines and supports necessary to allow the outcome to be satisfactorily achieved in a natural environment.

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Signatures

Non-EI Services (any services the child and family needs or is receiving through other sources, but that are neither required nor funded under Part C):

I (parent or guardian) have participated in the development of this Individualized Family Service Plan and understand that I can accept or refuse any or all of the services identified in it. I understand that my consent for services may be withdrawn at any time.

I further understand that my signature below indicates that: (a) I have been fully informed of the services being proposed; (b) I have received the Baby Watch Parents' Rights in Early Intervention Booklet and understand my parent rights in early intervention; and (c) I give consent to carry out our Individualized Family Service Plan as written.

Parent or Guardian Signature*

Date*

Parent or Guardian Signature*

Date*

Service Coordinator*

Date*

Person involved in evaluations and assessments*:

Date*

Participated by:

-conference call: _____
(Name)

Date:

-sending a representative _____
(Name)

Date:

-making pertinent records available by:

Mail: _____
(Name)

Date:

Email: _____
(Name)

Date:

Written input: _____
(Name)

Date:

Video conference: _____
(Name)

Date:

Other:

Date:

Other:

Date: