

Pottawatomie/Wabauwsee  
Infant/Toddler Program

Individualized Family Service Plan

For:



**tiny-k**

Early Intervention Services

### Know Your Rights Abbreviated Summary

- 1) The right to consent. That means the Early Childhood Team must have your permission before your child is evaluated, receives early intervention services, or services are added, discontinued or changed.
- 2) The right to a full evaluation of your child's needs. If you don't agree with what the evaluation team determines, you can obtain an independent evaluation. Information on your right to obtain an independent evaluation is available from Pottawatomie/Wabaunsee Infant Toddler Program.
- 3) The right to see what records are kept regarding your child, the right to know where they are kept and to obtain a copy. These records include assessments, reports, and other information the network has on file for your child. Access to these records may be obtained through an appointment with the family service coordinator or by calling the Coordinator at 785-456-7366.
- 4) The right to privacy of information. No one may see your child's records unless you give your permission in writing. The only people who don't have to obtain that permission in writing are people like your child's teacher or other related service staff who are planning for your child's program. Officials from Kansas Department of Health and Environment and Kansas Department of Education oversee the program and conduct audits/reviews of paperwork. Your consent to enroll in the program allows these agencies to review you child's paperwork/data as needed. Purpose of review by these agencies is for program evaluation.
- 5) The right to help develop your child's IFSP and to be part of the IFSP meeting.
- 6) The right to request a review of the IFSP at any time if you feel your child's needs have changed or services should be modified to better meet your child's needs. It is important to notify the family service coordinator or other service providers of your desire to review the IFSP, so modifications can be discussed.

\* Complete parental rights will be given to families upon initial visit, additional copies are available upon request.

Child's Name:

IFSP Date:

# Pottawatomie/Wabauunsee Infant Toddler Program

## Individualized Family Service Plan



Early Intervention Services

Child Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Adjusted Age: \_\_\_\_\_

Parent/Guardian(s): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Race/Ethnicity: \_\_\_\_\_ Primary Language: \_\_\_\_\_ School District: \_\_\_\_\_

Physician/Health Care Provider: \_\_\_\_\_ Address/Phone: \_\_\_\_\_

Medical Diagnosis: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Medicaid #: \_\_\_\_\_

Additional Services Accessed: \_\_\_\_\_

Family Service Coordinator: \_\_\_\_\_

Referral Source: \_\_\_\_\_

Referral to ITS Date: \_\_\_\_\_

Initial IFSP Date: \_\_\_\_\_

Initial Implementation Date: \_\_\_\_\_

Current IFSP Date: \_\_\_\_\_

6 Month Review Date: \_\_\_\_\_

Annual Review Date: \_\_\_\_\_

Transition Meeting Date: \_\_\_\_\_

Eligibility for Early Intervention Services Determined By:

- Evaluations
- Medical Diagnosis or Combination of Risk Factors
- Clinical Judgment

Child's Name: \_\_\_\_\_

IFSP Date: \_\_\_\_\_

# Health History

Prenatal/Birth Story:

Birth Weight: \_\_\_\_\_ Length: \_\_\_\_\_ Full Term?: yes/no \_\_\_\_\_ Weeks Premature: \_\_\_\_\_

Overall Health Since Birth: \_\_\_\_\_

Recurring Illnesses: \_\_\_\_\_ Medications: \_\_\_\_\_

Specialists Seen: \_\_\_\_\_

Significant Family Health History (Parents, Siblings): \_\_\_\_\_

Most current health screening: \_\_\_\_\_ Immunizations up-to-date: yes/no \_\_\_\_\_

Date of Last Vision screening: \_\_\_\_\_

Location: \_\_\_\_\_

Results: \_\_\_\_\_

Meets definition of Legal Blindness: yes/no \_\_\_\_\_

Date of Last Hearing Screening: \_\_\_\_\_

Location: \_\_\_\_\_

Results: \_\_\_\_\_

Meets definition of Hearing Impaired/Deafness: yes/no \_\_\_\_\_

Child's Name: \_\_\_\_\_

IFSP Date: \_\_\_\_\_

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What your child is doing now...

Development	Initial	6 month update
Cognitive/Thinking (learning, playing, interacting with environment)		
Communication and Language (expressing wants and needs, understanding communication)		
Self-help (eating, sleeping, dressing)		
Social – Emotional (interacting with others, being with people, displaying emotions)		
Motor (using eyes, hands, and arms; walking, running, and kicking)		

Child's Name:

IFSP Date:

**Family Information**

**Important people, places and events: (resources, strengths, supports)**

**Child & Family Interests:**

**Family Priorities:**

Child's Name:

IFSP Date:

# Family & Child Outcomes

Date: \_\_\_\_\_

Outcome # _____ What do we want to happen?		
What's happening now related to this outcome?		
How will we know we're making progress? What will be different?		
<b>Date</b>	<b>Rating</b>	<b>Comments</b>

Outcome # _____ What do we want to happen?		
What's happening now related to this outcome?		
How will we know we're making progress? What will be different?		
<b>Date</b>	<b>Rating</b>	<b>Comments</b>

1. Situation changed, no longer a need
2. Situation unchanged, still a need or goal
3. Outcome partially attained or accomplished
4. Outcome accomplished or attained, but not to the family's satisfaction
5. Outcome completely accomplished or attained to the family's satisfaction

Child's Name: \_\_\_\_\_

IFSP Date: \_\_\_\_\_

### Early Intervention Services and Supports

IFSP Team	Service Provider & Discipline	Natural Environments/ Location of Services	Method	How Often	How Long	Start Date	End Date	Payment	Parents Initial for Services Added
Primary Service Provider									
Additional Supports									

### Other Community Partners providing support to the family: (child care, PAT, church, play/support groups, medical providers, etc.)

Name of Partner	Service Provided	Information (name, phone #, etc.)

\*\*Your child and family have access to a team of early intervention service providers who have expertise in early childhood development and meet established standards in their individual fields of practice.

Child's Name:

IFSP Date:

**Present at this meeting:**

<u>Name</u>	<u>Title/Agency or Relationship</u>	<u>Date</u>

**Copies of this IFSP will be sent to:** \_\_\_\_\_

**Transition plan needed within the next 6 months?** No: \_\_\_\_\_ Yes: \_\_\_\_\_ (If yes, see attached transition plan)

**Informed Consent by Parents:**

Please Initial:

\_\_\_\_\_ I have been informed/understand my rights under this program.

\_\_\_\_\_ I give permission to carry out this IFSP.

\_\_\_\_\_ I agree to receive services through consultation or direct support in community settings where other children and adults may be present and where confidentiality may be compromised.

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Child's Name:

IFSP Date: