NYC Early Intervention Program
Notice of IFSP Meeting

_____ _____
Parent's Name Date

_____

_____
Address

Dear _____,

As we discussed, an IFSP meeting has been scheduled for your child. The IFSP meeting will be held on (date/time) _____ at (location) _____

As we also discussed, if available, please bring the following information to the meeting:

1. Health insurance information;
2. Social Security Numbers for you and your child;

If you do not have some of this information, services will still be authorized for your child and family.

You have the following rights at the IFSP meeting:

1. You have the right to participate in the IFSP meeting where the needs of your child and family are discussed and a service plan is developed.
2. You have the right to consent to or refuse to consent to any services recommended at the IFSP meeting. If you give consent for services, you can withdraw it at any time.
3. You have the right to review and obtain copies of all records used for the meeting.
4. You have the right to disagree with some parts of the IFSP and you may file a systems complaint or request mediation or an impartial hearing (due process). Please refer to **A Parent's Guide to the Early Intervention Program** if you need more information:
www.health.state.ny.us/community/infants_children/early_intervention
5. If you request due process, all services in dispute must continue without change until after the mediation and/or impartial hearing is held.

If the time or place listed above is not convenient for you or you have any additional questions, we can reschedule this meeting. Please call me at (_____)_____ if you have any questions.

Sincerely,

_____ _____
Name Title

Programa de Intervención Temprana de la Ciudad de New York
Notificación de la Reunión Individualizada de Servicios para la Familia

_____ _____
Nombre de Padre Fecha

_____
_____
Dirección

Estimado _____,

Como acordamos anteriormente, una reunión para desarrollar un plan de servicios individualizado para la familia (IFSP) ha sido programada para su niño/a.
La reunión se llevara a cabo el _____en _____.

Como también acordamos, si los tiene disponible, por favor traiga con usted la siguiente información:

1. Información sobre seguro medico
2. Números de Seguro Social para usted y su niño/a.

Si no tiene esta información, esto no impide que se le autoricen los servicios para su niño y familia.
Usted tiene los siguientes derechos en esta reunión:

1. Tiene derecho de participar en la reunión donde se hablara sobre las necesidades de su niño/a y familia y se desarrollará un plan de servicios.
2. Tiene el derecho de dar su consentimiento o rehusar a dar su consentimiento a cualquiera de los servicios recomendados en la reunión. Si da su consentimiento, puede revocar ese consentimiento en cualquier momento.
3. Tiene el derecho a revisar y obtener copias de todos los documentos usados en esta reunión.
4. Tiene el derecho de estar en desacuerdo con algunas partes del plan de servicios y puede pedir una mediación y/o una audiencia imparcial. Por favor refiérase a la Guía para los Padres del Programa de Intervención Temprana si necesita mas información:
   www.health.state.ny.us/community/infants_children/early_intervention
5. Si pide una mediación y/o audiencia imparcial, todos los servicios que se disputan continuaran sin cambios hasta que la mediacion y/o audiencia imparcial se lleve a cabo.

Si el lugar o la hora de esta reunión no son convenientes para usted o tiene preguntas adicionales, podemos cambiar la fecha. Por favor llámeme al _____ con sus preguntas.

Sinceramente,

_____ _____
Nombre Titulo

IFSP FORMS

INDIVIDUALIZED FAMILY SERVICE PLAN
IDENTIFYING INFORMATION (Page 1)

Child's Name: (Last) _____ (First) _____
EI #:_____ DOB: ____/ _____/ _____
Today's Date: _____/ _____/ _____ Gender: [ ] M [ ] F

IFSP meeting held within 45 days? [ ] YES [ ] NO
(If no, verify reason for delay on Transmittal Form)

IFSP Meeting (check as appropriate): ☐Interim ☐Initial ☐6 month ☐12 Month ☐18 Month ☐24 Month ☐30 Month ☐36 Month ☐Amended
(If this is an Amendment meeting, check *amended* and the IFSP period) ☐ Transition Conference ☐ Transition Plan (check the transition conf./plan box and the IFSP period)
Date of Initial IFSP :_____/_____/_____ At initial IFSP, write effective dates: 6 Month Review: _____/_____/_____ Annual IFSP: _____/_____/_____

Mother's/Guardian's Name: _____ Father's/Guardian's Name:_____
Child's Address: _____Apt. # _____ Zip Code_____ Parents' Language: _____
(Street) (Borough/City)
Home Phone #: (_____) _____Alternate Phone #: (_____) _____ Cell Phone #: (_____) _____

Is child in foster care: ( ) No ( ) Yes **If yes, please fill out the following information:**
Foster Parent/Surrogate's Name: _____ Agency: _____ Caseworker's Name: _____

Agency Address: _____ Phone #: (_____)_____
Fax # : (_____)_____

Ethnicity: ☐Hispanic ☐Not Hispanic **Race**: ☐White ☐Black ☐Native American or Alaskan ☐Asian ☐Native Hawaiian/ Other Pacific Islander
NOTE: More than one racial category can be checked.

IFSP Participants:	**Print Name:**	**Agency:**	**Signature:**
☐ Parent ☐ Legal Guardian ☐ Foster Parent			
☐ Early Intervention Official Designee			
☐ Initial SC ☐ Ongoing SC ID #: Phone #: ( )			
☐ Evaluator ☐ Interventionist			
☐ Other			

Health/ Medical Information

Diagnosis: **Medical Alerts:**

INDIVIDUALIZED FAMILY SERVICE PLAN (Page 2)
CURRENT DEVELOPMENT, and FAMILY CONCERNS

Child's Name: (Last) _____ (First) _____
EI #:_____ DOB: ____/ _____/ _____Today's Date: ____/ _____/ ____

Concerns: What my (parent) concerns are: (Provide example(s) of how daily routines are affected/ when this concern is most noticeable to the parent/family.)

Motor: Ability to get around- gross motor (ex: sitting, rolling, standing, crawling, walking), handling small objects- fine motor, sensory skills) hearing, vision.
Parent Concern: ☐ *I have no concerns in this area at this time.* ☐ *Parent is concerned about this area of development (provide examples):*

_____
_____
_____
_____

MDE Results: ☐ *There are no concerns at this time; the child is developing typically in this domain.* ☐ *The evaluation results indicate concerns (Concern in attached MDE Summary):*

Adaptive: Sucking, eating solid foods, drinking from a cup. Sleeping, dressing, toileting.)
Parent Concern: ☐ *I have no concerns in this area at this time.* ☐ *Parent is concerned about this area of development (provide examples):*

_____
_____
_____
_____

MDE Results: ☐ *There are no concerns at this time; the child is developing typically in this domain.* ☐ *The evaluation results indicate concerns (Concern in attached MDE Summary):*

Communication: Understanding what is being said, using sounds, words or gestures to let others know what he/she needs.
Parent Concern: ☐ *I have no concerns in this area at this time.* ☐ *Parent is concerned about this area of development (provide examples):*

_____
_____
_____
_____

MDE Results: ☐ *There are no concerns at this time; the child is developing typically in this domain.* ☐ *The evaluation results indicate concerns (Concern in attached MDE Summary):*

Cognitive: Thinking, Learning, Using Toys, Paying Attention, Controlling Environment
Parent Concern: ☐ *I have no concerns in this area at this time.* ☐ *Parent is concerned about this area of development (provide examples):*

_____
_____
_____
_____

MDE Results: ☐ There are no concerns at this time; the child is developing typically in this domain. ☐ The evaluation results indicate concerns *(Concern in attached MDE Summary)*:

Social Emotional: Relating to and getting along with adults and children, getting used to new places and expressing emotions (self-calming)
Parent Concern: ☐ *I have no concerns in this area at this time.* ☐ *Parent is concerned about this area of development (provide examples)*

_____
_____
_____
_____

MDE Results: ☐ *There are no concerns at this time; the child is developing typically in this domain.* ☐ *The evaluation results indicate concerns (Concern attached in MDE Summary):*

INDIVIDUALIZED FAMILY SERVICE PLAN
DAILY ROUTINES, PARENT PRIORITIES and RESOURCES (Page 3)

Child's Name: (Last) _____ (First) _____
EI #:_____ DOB: ____/ _____/ _____
Today's Date: _____/ _____/ _____

When early intervention services are provided in places where your family typically lives, learns and plays, (family's daily routine/natural environment), progress is made more quickly. Young children learn best by socializing and playing with people they are close to(parents, family members, babysitters, childcare workers, and other children), and in places they know and like. The questions on this page will help families identify natural learning opportunities throughout the child's day and, how interventions can be made a part of your daily activities.

Priorities:

1. Based on our conversation, which of your child's daily routines and activities would you like Early Intervention to help you work with your child on (ex: **At home**: bath time, meal time, naps, dressing/ **Outside:** Shopping, attending childcare, visiting friends or family **Events**: Family get-togethers/ Places parent and child go together)?

2. Based on your answer(s) to the last question, which concern(s) would you like Early Intervention to focus on (if more than one, list them in order of priority)?

Resources: (This Section must be filled out by the ISC with the parent/guardian before the IFSP meeting)

1. Where does your child spend most of his/her time during a typical day? (Some of these places may be possible sites for early intervention activities)
   ☐ *****Daycare/ Child Care Program/ Babysitter ☐ At home ☐ Other_____

If child attends Daycare/ Child Care Program/ Babysitter, please fill out the following:
Name of caregiver, or program: _____
Address_____ Phone #: (_____) _____

2. If your child is not in a Daycare/ Child Care Program/ Babysitter who assists you with childcare? ☐ Grandparent ☐ Friend ☐Other_____

3. What language does your child hear most of the day? _____

INDIVIDUALIZED FAMILY SERVICE PLAN
FUNCTIONAL OUTCOMES (Page 4)

Child's Name: (Last) _____ (First) _____ EI #:_____

DOB: / / Today's Date: / / Date of Review: / /

Functional Outcome: A practical result that your child will gain as a result of Early Intervention supports and services in the next 6 months

Note: Outcomes are not discipline specific. Interventionist must work together on all outcomes identified in the IFSP.

1. Functional Outcome:	**2.** Functional Outcome:
Objectives: Short term goals that should be achieved in order for the child to reach the functional outcome:	Objectives: Short term goals that should be achieved in order for the child to reach the functional outcome:
Six Month Review: Will this outcome: ☐ Continue ☐ Be Revised (Complete new outcome page) ☐ Discontinue	Six Month Review: Will this outcome: ☐ Continue ☐ Be Revised (Complete new outcome page) ☐Discontinue
Progress Note Dates:	**Progress Note Dates:**
3. Functional Outcome:	**4.** Functional Outcome:
Objectives: Short term goals that should be achieved in order for the child to reach the functional outcome:	Objectives: Short term goals that should be achieved in order for the child to reach the functional outcome:
Six Month Review: Will this outcome: ☐ Continue ☐ Be Revised (Complete new outcome page) ☐ Discontinue	Six Month Review: Will this outcome: ☐ Continue ☐ Be Revised (Complete new outcome page) ☐Discontinue
Progress Note Dates:	**Progress Note Dates:**

_____ _____ _____

Signature of Person Completing ☐6 ☐18 ☐30 mo Review **Signature of Parent/Guardian (at Review)** **Signature and Stamp of EIOD (at Review)**

INDIVIDUALIZED FAMILY SERVICE PLAN
Service plan (Page 5): Settings and Incorporating interventions into natural routines.

Child's Name: (Last) _____ (First) _____
EI #:_____ DOB: ____/ _____/ _____
Today's Date: _____/ _____/ _____

Are all services being provided in child's **natural environment**? ☐Yes ☐No
If no, explain.

If any service is being provided in **group settings** without typically developing peers, explain why the IFSP team agrees this is appropriate:

If the family is unable to be present during therapeutic sessions with the child, how will the service provider communicate with the family to assist them in learning ways to improve the child's functioning in his/her natural environment:

☐ Calendar
☐ Notebook
☐ Phone Calls
☐ Other:

How will interventions be made a part of your daily routines and activities?	Teacher/therapist responsibilities:
➢ Teacher/therapist will utilize child's play, mealtime, bathing, dressing, bedtime, morning routine, shopping, playground, family events, and weekends activities for individual intervention ➢ Parent/Caregiver will participate in intervention sessions when possible and incorporate teacher/therapist suggestion into child's daily routine ➢ Teacher/therapist will communicate on a regular basis with parent/caregiver, other interventionist, and day care/child care providers to coordinate strategies and accommodate the needs of the child (if child is in a daycare setting).	➢ Teacher/therapist will provide a schedule of agency holidays and planned time off to the parent/caregiver at the beginning of the authorization period ➢ Teacher/therapist will review and provide a copy of each progress note to the parent/caregiver. ➢ Teacher/therapist will submit completed progress notes to the service coordinator at least 2 weeks before each 6 month review period.

INDIVIDUALIZED FAMILY SERVICE PLAN
SERVICE AUTHORIZATION FORM Page 5a

CHILD INFO: Child's Name: (Last) _____ (First) _____
(Middle) _____ EI #:_____ DOB: ____/ _____/ _____
Effective Date of IFSP: _____/ _____/ _____ End Date of IFSP: _____/ _____/ _____

TYPE OF IFSP
❑ Interim ❑ Initial
❑ 6 Month
___6 ___18 ___30
❑ Annual
___12 ___24 ___36
❑ Amendment to IFSP
Dated:
_____/_____/_____

PROVIDER INFORMATION (USE ONE SHEET PER SERVICE PROVIDER)
PROVIDER NAME:
_____
PROVIDER EI #: _____
CONTACT PERSON: _____
CONTACT PERSON'S PHONE: (_____) _____
CONTACT PERSON'S FAX: (_____) _____
SC: _____ SC #: _____
PHONE: (_____) _____ FAX: (__)_____

Service Provider not identified at time of IFSP for the following services (Pended):
Service Type: Frequency/ Duration Authorized:
1. _____
2. _____
3. _____
4. _____
5. _____
OSC will identify provider by _____/_____/_____
NOTE: OSC must contact EIOD if provider is not identified within two weeks

EIOD Name _____ DATE: _____/_____/_____
EIOD Signature:

NOTE: The Service Authorization Form is only valid if signed by the EIOD. A separate Service Authorization Form must be completed for each service provider.

Insurance Information must be completed and updated at each IFSP, including amendments. If the child is enrolled in a Medicaid Managed Care Plan, include child's Medicaid number, as well as insurance Company Information.
Child Medicaid Eligible: □ Yes □ No
Child's Medicaid OR CIN #: ___/ ___/ ___/ ___/ ___/ ___/ ___/ ___
Ltr / Ltr / # / # / # / # / # / Ltr

Private Insurance Name (Do not write Child Health Plus)
Insurance Company Name: _____
Policy Holder Name: _____ DOB: ____/ ____/ ____
Relationship to Child: _____Policy #: _____
Group Name: _____Group #: _____
Effective Date: _____/ _____/ _____

1: SERVICE TYPE Use code letters for Service, Method and Location (See back for KEY)		2: Method	3: Location	4: Begin Date	5: End Date	6: Min per visit	7: Days per week	8: Weeks	9: Units	10: Waiver Code(s)		11: Status	Provider Instructions 12: Bilingual Request?	Provider Instructions 13: Prescription Needed?
1: TYPE SVC *Code Letter*	_____	_____	_____							Waiver Code(s)	_____ Initial Start date:	☐ ADD ☐ END	☐	☐ PT ☐ OT ☐ Nursing
2: TYPE SVC *Code Letter*	_____	_____	_____							Waiver Code(s)	_____ Initial Start date:	☐ ADD ☐ END	☐	☐ PT ☐ OT ☐ Nursing
3:TYPE SVC *Code Letter*	_____	_____	_____							Waiver Code(s)	_____ Initial Start date:	☐ ADD ☐ END	☐	☐ PT ☐ OT ☐ Nursing
4: TYPE SVC *Code Letter*	_____	_____	_____							Waiver Code(s)	_____ Initial Start date:	☐ ADD ☐ END	☐	☐ PT ☐ OT ☐ Nursing
5: TYPE SVC *Code Letter*	_____	_____	_____							Waiver Code(s)	_____ Initial Start date:	☐ ADD ☐ END	☐	☐ PT ☐ OT ☐ Nursing

Data Entry Name: _____ *Date:* _____/_____/_____

INDIVIDUALIZED FAMILY SERVICE PLAN (Page 5B)
Service plan: Co-Visits (Use ONLY if co-visits are authorized)

Child's Name: (Last) _____ (First) _____
EI #:_____ DOB: ____/ _____/ _____
Today's Date: _____/ _____/ _____

Check the purpose of co-visit(s):

☐ Provide co-treatment for child targeting an area of child need in which 2 or more qualified personnel are providing different interventions.

☐ Enable professionals and parents/caregivers to work together to assess child progress and problem-solve on emerging issues related to child and family needs across the areas of needs that are being addressed by differently qualified personnel.

OR

☐ Provide education, training, and instruction to the parent/designated caregiver in use and integration of particular techniques and strategies to enhance the child's development and functioning in the area of need being addressed by the professionals.
(NOTE: Checking this box requires the use of Family Training as the service type.)

Functional outcome(s) addressed by co-visit: _____

_____

_____

_____

_____

_____

_____

Participants: ☐ Parent/Caregiver ☐ ST ☐ PT ☐ OT ☐ SI ☐ SW ☐ Other _____

☐ FT (Indicate number and disciplines of participants)_____

Method: ☐ Office/Facility Individual/Collateral ☐ Basic Home/Community Individual/Collateral ☐ Extended Home/Community Individual/Collateral

Location: ☐ Home ☐ Center ☐ Other_____ **Frequency:** _____

Authorization: ☐ Use existing authorized units ☐ Additional units to be authorized Waiver needed? ☐ Yes ☐ No

Comments:

NOTE:
If one or more of the interventionists involved in a co-visit is unable to participate in a scheduled visit, s/he is responsible for contacting the Service Coordinator to request that the co-visit be rescheduled.

The Ongoing Service Coordinator should review the IFSP and, if co-visits are authorized, contact parents and interventionists to coordinate the co-visits.

INDIVIDUALIZED FAMILY SERVICE PLAN (Page 6)
SERVICE PLAN: TRANSPORTATION, ASSISTIVE TECHNOLOGY AND RESPITE SERVICES

Child's Name: (Last) _____ (First) _____
EI #:_____ DOB: ____/ _____/ _____
Today's Date: _____/ _____/ _____

Transportation

Transportation services are authorized to enable an eligible child and the child's family to receive Early Intervention services. As per New York State Early Intervention Program Regulations at 10NYCRR, Sec 69-4.19 (b). "…consideration shall first be given to provision of transportation by a parent of a child…" **Transportation options are evaluated in the following order.**

☐ No transportation needed.

☐ Caregiver will transport child either by: ☐ Public Transportation ☐ Private car **Is reimbursement being requested?** ☐ Yes ☐ No

☐ If the Caregiver is unable to transport the child state the reason:_____

The Early Intervention Program will provide transportation by:

☐ School bus

☐ Car Service. If requesting this mode please state reasons why other forms of transportation are not appropriate:

_____

Are there any other needs (e.g., nurse on bus)? _____

Assistive Technology Device Needs:

Names/categories of AT equipment:_____

Reason AT device needed to achieve functional outcome._____

☐ Form attached ☐ Form to be completed ☐ Continued assessment needed ☐ Child currently has AT equipment ☐ Not applicable

Respite Services

Respite is short term, temporary care provided by a trained respite worker or nurse. It is intended to provide support to parents and caregivers who may otherwise be overwhelmed by the intensity and constancy of caregiving responsibilities for their child with special needs. Respite is not a substitute for daycare and the need for childcare is not sufficient alone to justify respite services. *The New York City Early Intervention Program determines the need for respite services based upon the individual needs of the child and family with consideration given to New York State Public Health Laws*.

Does the family express the need for respite services? ☐ Not at this time ☐ Yes ☐ Application attached ☐ Application to be submitted

Has the family applied for other sources of respite? ☐ Not eligible ☐ No *Explain why not.*_____

☐ Yes Give *source, date of application and current status.*_____

NYC EARLY INTERVENTION PROGRAM **A.T. DEVICE DATA ENTRY FORM** **FOR OFFICE USE ONLY**

EFFECTIVE DATE OF IFSP: _____/_____/_____

END DATE OF IFSP: _____/_____/_____

CHILD INFORMATION:

CHILD EI #: _____ DOB:_____/_____/_____

CHILD'S NAME: _____
(LAST)

_____
(FIRST) (MIDDLE)

Borough:

PROVIDER INFORMATION (USE ONE SHEET PER SERVICE PROVIDER)

PROVIDER NAME: _____

PROVIDER EI #: _____

CONTACT PERSON: _____

CONTACT PERSON'S PHONE: (_____) _____

CONTACT PERSON'S FAX: (_____) _____

SC: _____ SC #: _____

PHONE: (_____) _____ FAX: (_____) _____

TYPE OF IFSP

❑ Interim ❑ Initial

❑ 6 Month

___6 ___18 ___30

❑ Annual

___12 ___24 ___36

❑ Amendment to IFSP

Dated: _____/_____/_____

NOTE: The Service Authorization Form is only valid if signed by the EIOD. A separate Service Authorization Form must be completed for each service provider.

EIOD NAME: _____ DATE:_____/_____/_____

EIOD SIGNATURE: _____

Vendor: ***Catalog:*** ***Dispensary:***

1: CATEGORY/ CODE		2 : CPT/HCPCS CODE	3: AT ITEM/ DEVICE DESCRIPTION	4: BEGIN DATE	5: END DATE	6: QUANTITY	7: COST	8: TOTAL COST	9: STATUS
1-CATEGORY ---------- CODE	Asst. Tech ---------- I								ADD END
2-CATEGORY ---------- CODE	Asst. Tech ---------- I								ADD END
3-CATEGORY ---------- CODE	Asst. Tech ---------- I								ADD END
4-CATEGORY ---------- CODE	Asst. Tech ---------- I								ADD END
5-CATEGORY ---------- CODE	Asst. Tech ---------- I								ADD END

Data Entry Signature:_____ Date: _____ / _____ / _____

NYC EARLY INTERVENTION PROGRAM **TRANSPORTATION SERVICE DATA ENTRY FORM** **FOR OFFICE ONLY**

CHILD'S NAME:

_____
Last First MI

EI # _____

DOB _____/_____/_____

IFSP: **[ ] Initial [ ] 6-Month [ ] Annual [ ] Amended [ ] Interim**

Effective date of IFSP: ____/____/____
End date of IFSP: ____/____/____

EIOD (print): _____

EIOD signature_____
Date: _____/_____/_____

TRANSPORTATION PROVIDER INFORMATION
Transportation Provider Name:
_____

Provider EI # _____

Contact person: _____

Phone: (_____)_____
Fax: (____)_____

DESTINATION INFORMATION

Agency name: _____

Agency EI#: _____

Site address: _____
_____

Trans. Coord.: _____

Phone: (____)_____
Fax: (____) _____

Service Coordinator:

Name (print): _____
SC ID #: _____

Agency Name: _____

Agency #:_____

Phone: (____)_____

Fax: (____) _____

Data Entry Unit Only - For Bus Contract Change
Prior Bus Effective End Date is: ____/____/____
New contracted bus transportation name:
_____
Provider EI # _____

Contact person: _____
New Contract Date -
Begin: ____/___/___ End: ____/____/___
Weeks: _____ Total # Units: _____
Phone: ( ) _____
Fax: ( ) _____

Service Type: Bus ❑ Other ❑ **Code**_____	**Begin Date**	**End Date**	**Days per week**	**# Weeks**	**# Units (bus only)**	**Status**
Name Companion(s): 1. _____ 2.	Child	Child	M T W Th Fri Total # days per week:	Child	Child	[ ] Add [ ] End
Reason (bus only) :	Companion (bus only)	Companion (bus only)	M T W Th Fri Companion Total # days per week:	Companion (bus only)	Companion (bus only)	[ ] Add [ ] End

IF ANY OF THE INFORMATION BELOW CHANGES THE EIOD MUST BE NOTIFIED IN WRITING

Parents/Guardians Name(s):
_____
_____
Home #: (_____)_____
Work #: (_____)_____
Cell #: (_____)_____
Address (if different from pick up):

Pick up address/ phone:
_____
_____
Drop off address/phone:
_____
_____
Child travels with the following equipment:

Emergency Contact Name(s):
1. _____
Relation:_____
Home #:(_____)_____
Work #: (_____)_____
Cell #: (_____)_____

Check as appropriate:
[ ] Ambulatory
[ ] Non-ambulatory
[ ] Wheelchair vehicle
[ ] Needs special safety seat
[ ] Other (specify)

EIP Data Entry: _____Date:_____

INDIVIDUALIZED FAMILY SERVICE PLAN
SERVICE COORDINATION ACTIVITES (Page 7)

Child's Name: (Last) _____ (First) _____
EI #:_____ DOB: ____/ _____/ _____
Today's Date: / /

SC Primary Roles:

- Coordinate and monitor the delivery of all services.
- Assist families in obtaining EI and non-EI services.
- Facilitate reviews of IFSP every 6 months.
- Inform caregivers of their rights and procedural safeguards under the Early Intervention Program.
- Obtain and update insurance information and explain to parents how information will be used by EI.
- Discuss transition from EI when the child is 24 or more months old.

I have been given the option of choosing an ongoing service coordinator (OSC) and I have selected:
Name of OSC _____SC ID #_____

Tel. No. _____ Ext._____ Email_____

Provider Agency_____ Provider # _____

Parent's signature_____
Ongoing SC should:
□ Assist family in identifying and applying for Public Programs (e.g., Child Health Plus, Medicaid, Medicaid Waiver, WIC, Lead Program, housing). **List the programs**:

□ Assist family in identifying and applying for other non-EI services needed by child/family (e.g., child care, counseling, recreation services). **List the services:**

□ Coordinate **co-visits**; reschedule if necessary.
□ Locate **bilingual services**. If unavailable, contact EIOD to discuss alternatives.
□ Assist family with **transition**; complete pages 7A and 7B if child is 2 years or older.

Primary Health Care Provider:_____ Name of Medical Center/Facility_____
Address:_____ Phone #: (_____)_____ Fax #: (_____)_____

☐ I give permission for my service coordinator to send a copy of the IFSP and evaluation reports to my child's primary health care provider

☐ I do not give permission.

Signed:_____ Date: _____/_____/_____

If Parent/Guardian/Surrogate chooses to send the IFSP to others working with their child, such as Early Head Start, or Child Care Providers, complete "Parental Consent to Obtain/Release Information" form.

Additional Concerns: Describe below any concerns (from any members of the IFSP team) that may need follow-up.

Any further evaluations needed? □ Yes □ No Specify what type and why:

INDIVIDUALIZED FAMILY SERVICE PLAN
Transition Plan (Page 7A):

Child's Name: (Last) _____ (First) _____
EI #:_____ DOB: ____/ _____/ _____
Today's Date: _____/ _____/ _____ Child's Age: _____

INFORMATION REGARDING TRANSITION: Pages 7A and B must be completed for any child leaving EI, regardless of his/her age. These pages must be filled in at the IFSP closest to the child's 2nd birthday and updated at each subsequent IFSP. For children entering the EIP after age 2, these pages must be completed at the initial IFSP.

1. Children who complete their IFSP outcomes or no longer require EI services may exit EIP at any time prior to the third birthday. My service coordinator is responsible for helping me identify, locate, and provide access to other early childhood programs when appropriate.

2. If the parent is considering CPSE services, the following steps will need to be taken:

a. **NOTIFICATION:** I understand that I will need to give written consent to notify the CPSE of my child's potential eligibility. Notification must occur by _____/_____/_____ to Region/ District _____.

b. **TRANSITION CONFERENCE:** I understand that if I choose to request that my EIOD arrange a transition conference with my service coordinator and the chair of the CPSE or designee, I will need to give written consent for a transition conference which will be held by _____/_____/____,

c. **REFERRAL:** I understand that it is my responsibility to refer my child to the CPSE. My service coordinator can assist me if I ask. Any delays on my part to refer my child may potentially interfere with the ability of the CPSE to establish eligibility before my child's third birthday. Referral must occur by _____/_____/_____.

3. I am aware that all EI services will end on the day before my child's 3rd birthday: _____/ _____/ _____, if my child is not found eligible for CPSE services. If my child does not need preschool special education programs and services, or if I choose not to refer my child to the CPSE, my service coordinator is responsible for helping me identify, locate and access other early childhood programs.

The above information has been explained to me. **Parent's signature**: _____ **Date**: _____/_____/_____

Parent has chosen NOT to: (initial as appropriate):
_____ Send Notification to the CPSE
_____ Consent to a transition conference.
_____ Refer child to the CPSE at this time.

_____ I understand that all EI services will end the day before my child's 3rd birthday: ____/____/____

Parent's signature: _____ **Date**: _____/_____/_____

INDIVIDUALIZED FAMILY SERVICE PLAN
Transition Plan (Page 7b)

Child's Name: (Last) _____ (First) _____
EI #:_____ DOB: ____/ _____/ _____
Today's Date: _____/ _____/ _____ Child's Age: _____

TRANSITION PLAN:

1. What types of setting/services are being considered? Discuss various options for programs and/or services when the child exits EI, such as home, Early Head Start, Head Start, child care, private preschool, play group, preschool special education programs and services through CPSE, OMRDD, etc. **At this time we are interested in the following options:**

2. Date by which steps to prepare the child and family to adjust to a new setting should begin _____/_____/_____
(6 mo. prior to discharge or when child is leaving EI before his/her third birthday)

3. Describe steps to be taken to ensure a smooth transition? (Visit Early Head Start, day care centers, private preschools, etc.)

4. Who will assist?

My child is leaving EI before the third birthday for the following reason(s): _____.
I am aware that I may re-refer my child to EI before his/her third birthday if I have concerns about his/her development.
I am aware that I can refer my child to CPSE after his/her third birthday if I have concerns about his/her development.

Parent's Signature _____ Date _____ / _____ / _____

NOTE: Update this section at every IFSP meeting.

Notification sent to the CPSE on: _____ / _____ / _____
Transition conference was held on: _____ / _____ / _____
Child was referred to the CPSE on: _____ / _____ / _____
CPSE meeting is scheduled for: _____ / _____ / _____
CPSE meeting was held on: _____ / _____ / _____

Child was found **eligible** for preschool special education programs and services.
Last day of EI services: _____ / _____ / _____

Projected date of preschool services: _____ / _____ / _____

Child was found **not eligible**. Last day of EI services: _____ / _____ / _____

INDIVIDUALIZED FAMILY SERVICE PLAN
ATTESTATIONS, CONSENT FOR SERVICES
(Page 8)

Child's Name: (Last) _____ (First) _____
EI #:_____ DOB: ____/ _____/ _____
Today's Date: / /

- I received a copy of *A Parent's Guide* when my child was referred to Early Intervention. I understand my rights and I have received a verbal and written description of *My Family Rights* at this IFSP meeting.
- I understand that :
  - I can ask to read my child's file or request a change to the file.
  - I may refuse one or more services and continue to receive other early intervention services for my child or family.
  - I can contact my service coordinator or EIOD any time I have questions or concerns about this IFSP.
  - My child's services will be based on his or her continuing needs and eligibility. I will be notified if the EIOD makes any change to the IFSP.
  - I have the right to mediation or fair hearing if I disagree with any part of my child's IFSP.

- My family and I can use the services of the Early Intervention Program to help my child achieve our IFSP outcomes.
- I have been given a copy of the *EIP Policy on Make-up Sessions* and I understand when make-up sessions can be provided.

_____ _____ _____/_____/_____
Parent's Signature Parent's Signature Date

□ I (We) have participated in the development of this IFSP, and agree to all parts of this plan. I (we) give permission to the NYC Early Intervention Program to implement this plan with my family.

□ I (We) do not agree with some aspects of this plan. I (We) understand that I (we) have due process rights that are described in the *Parent's Guide* and that have been explained to me(us) at this meeting. I understand that disagreeing will not affect the other EI services. This is what I (we) do not agree with:

_____ _____ _____/_____/_____
Parent's Signature Parent's Signature Date

EVALUATION REPRESENTATIVE:

I certify that I am a qualified professional as defined in the New York State Early Intervention Regulations, and that I am representing the Multidisciplinary Evaluation Team for the above-named child. I further certify that I have personally evaluated this child and /or have read the complete multidisciplinary evaluation, am knowledgeable about the clinical needs of this child and family, and am able to answer any questions regarding the child's evaluations and assist in developing functional outcomes and short term objectives during the IFSP meeting..

Signature: _____

Date:_____/_____/_____

EARLY INTERVENTION OFFICIAL DESIGNEE (EIOD):

I certify that the services that I have authorized in this IFSP are based upon the review of the documentation provided by the evaluators and the discussion that took place at this IFSP meeting as documented in the IFSP.
EIOD STAMP: