# NEW HAMPSHIRE FAMILY CENTERED EARLY SUPPORTS AND SERVICES
# INDIVIDUALIZED FAMILY SUPPORT PLAN (IFSP)

Start Date of IFSP: _____ End Date of IFSP: _____

Type: Initial Date: _____ Annual Date: _____ Review Date: _____ Addendum Date: _____

Child's name: _____ Date of Birth: _____ Duck # _____

Address: _____

Parent/Guardian: _____ Phone: _____

Address: _____

Parent/Guardian: _____ Phone: _____

Address: _____

Primary Language: _____ Family needs an interpreter. ☐Yes ☐No Race/Ethnicity: _____

Date of Initial Referral: _____ If found eligible, date initial IFSP must be completed by _____

Referral Source/How our family heard about ESS: _____

Area Agency: Lakes Region Community Services Contact: Nicole Bushaw

Primary Service Coordinator: _____

Phone: 603-524-8811 Email: _____

Program: LRCS Family Centered Early Supports and Services

Address: 719 North Main St, Laconia NH 03246

**IFSP Team Members** (at this meeting or not, who have helped in developing this plan.)

| **Agency** | **Name with Signature and Credentials** | **Title** | **Mode of Participation** (In-person, phone, video, etc.) |
|---|---|---|---|
| Family | | Parent | _____ |
| Family | | Parent | _____ |
| Family | | Other: | _____ |
| FCESS | | Interim Service Coordinator | _____ |
| FCESS | | Service Provider / Evaluator | _____ |
| FCESS | | Service Provider / Evaluator | _____ |

Child's Name: _____ Date of Birth: _____ Date of IFSP meeting: _____

## FAMILY ASSESSMENT SUMMARY

**Child Strengths:** What our child does well. What she/he enjoys doing.
_____

**Child Needs:** Areas of our child's development we would like help with so we can help our child.
_____

**Family Resources:** What our family enjoys doing together. What resources our family has (such as family/friends who help; groups that give supports).
_____

**Family Concerns:** What supports we'd like to know more about (see list below).
_____

**Family Priorities:** What is most important to us right now.
_____

Here is a list of example topics that your Service Coordinator can provide help with. There may be other topics that you would like help with that are not listed. These topics may also be used to help write family outcomes.

□Information about how children grow and develop
□Particular conditions which impact child development
□Activities to do with children
□Appropriate toys for children
□Other places in the community to get help
□Children's behavior and how to handle it
□Healthy meals and nutrition
□Resources for housing
□Resources for employment
□Resources for help with finances
□Other: _____

Child's Name: _____ Date of Birth: _____ Date of IFSP meeting: _____

## CHILD EVALUATION/ASSESSMENT SUMMARY

(This information comes from all the different reports and information gathered during the evaluation process and on-going assessments.)

| Area | Age Range (in months) | Developmental Description |
|---|---|---|
| **Cognitive** (Thinking, playing, exploring, and problem solving) | _____ Months | |
| **Communication** (Understanding others, expressing myself and use of language) | _____ Months | |
| **Social/Emotional** (Showing emotions, feelings, and interacting with others) | _____ Months | |
| **Adaptive/Self Help** (Calming self, eating, dressing, toileting and doing things for myself) | _____ Months | |
| **Fine Motor** (Using hands and fingers for feeding, play, and other activities) | _____ Months | |
| **Gross Motor** (Moving body to change position, location, and participate in activities) | _____ Months | |
| **Hearing** (Response to sound and spoken language) | **Has your child's hearing been tested?** ☐Yes ☐No **Concerns?** ☐Yes ☐No<br>Results of testing/observation of functional hearing: _____ | |
| **Vision** (How child uses his/her eyes) | **Has your child's vision been tested?** ☐Yes ☐No **Concerns?** ☐Yes ☐No<br>Results of testing/observation of functional vision: _____ | |
| **Sensory** (Response to light, sounds, touch) | _____ | |
| Adopted from MARYLAND INFANTS AND TODDLERS PROGRAM Individualized Family Service Plan (IFSP) March 2017 – Family Centered Early Supports and Services/NH Part C | | |

| Current Health Status (any medical concerns) | |
|---|---|
| **Child's primary doctor and phone #**<br>_____ | **Child's health status today:**<br>_____ |

Child's Name: _____ Date of Birth: _____ Date of IFSP meeting: _____

| **Health history/concerns:**<br>_____ | |
|---|---|
| **Other doctor(s) name and phone:**<br>_____ | **Other doctor(s) seen because:**<br>_____ |

**Assessment Tool Completed**: ☐ Hawaii Early Learning Profile (HELP)
☐ Infant-Toddler Developmental Assessment (IDA)

**Multidisciplinary Assessment Team Members** (other than family member[s] of assessment team)

| Assessor(s) (name and Title) | Date(s) of Assessment | Where It was Done |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

| **RECOMMENDATIONS / SUMMARY** |
|---|
| _____ |

| **ELIGIBILITY** |
|---|
| _____ **is eligible** for Family Centered Early Supports and Services based on:<br>☐ Developmental Delay in _____ area(s) of development.<br>☐ Atypical Behavior (Description) _____<br>☐ Established Condition of _____<br>☐ At Risk for Substantial Delay (based on 5 areas): _____<br>Informed Clinical Opinion Justification (as needed): _____ |
| _____ **is not eligible** for Family-Centered Early Supports and Services. |

Child's Name: _____ Date of Birth: _____ Date of IFSP meeting: _____

**Child Outcomes Summary (COS) Descriptors/Definitions**

(Discussion Tool)

| | | |
|---|---|---|
| **Overall Age Expected** | **7** | Child shows functioning expected for his/her age in all or almost all everyday situations that are part of the child's life. Functioning is considered appropriate for his/her age. No one has any concerns about the child's functioning in this outcome area. |
| | **6** | Child's functioning generally is considered appropriate for his/her age but there are concerns about the child's functioning in the outcome area. These concerns are substantial enough to suggest monitoring or possible additional support. Although age-appropriate, the child's functioning may border on not keeping pace with age expectations. |
| **Some Not Age Expected Some Age Expected** | **5** | Child shows functioning expected for his/her age some of the time and/or in some settings and situations. Child's functioning is a mix of age expectations and below age expected behaviors and skills. Childs functioning might be described as like that of a slightly younger child. |
| | **4** | Child shows occasional age expected functioning across settings and situations. More functioning is below age expectations than age expected. |
| **Not Age Expected** | **3** | Child does not yet show functioning expected for a child of his/her age in any situation. Child uses immediate foundational skills, most or all of the time, across settings and situations. Immediate foundational skills are the skills upon which to build age expected functioning. Functioning might be described as like that of a younger child.* |
| | **2** | Child occasionally uses immediate foundational skills across settings and situations. More functioning reflects skills that are not immediate foundational than are immediate foundational. |
| | **1** | Child does not yet show functioning expected of a child his/her age in any situation. Child's functioning does not yet include immediate foundational skills upon which to build age expected functioning. Child's functioning reflects skills that developmentally come before immediate foundational skills. Child's functioning might be described as like that of a much younger child.* |

*****The characterization of functioning like a younger child only will apply to some children receiving special services such as children with developmental delays.

Adopted from The Early Childhood Outcomes Center (ECO)
March 2017 – Family Centered Early Supports and Services/NH Part C

Child's Name: _____ Date of Birth: _____ Date of IFSP meeting: _____

## STRENGTHS AND NEEDS SUMMARY
## Child Outcome Summary (COS) Related to My Child's Development

*For children to be active and successful participants at home, in the community, and in places like childcare or preschool programs, they need to develop skills in three functional areas. We use information about your child's present levels of development, your family's concerns, resources and priorities, and your daily routines to understand your child's individual progress in relation to him/herself and to same age peers. This information supports the development of meaningful functional outcomes for your child and family.*

| HOW DOES MY CHILD…. | | MY CHILD'S STRENGTHS<br>What are some things my child likes to do? What skills does my child demonstrate or is beginning to demonstrate? | MY CHILD'S NEEDS<br>What are some skills or behaviors that my child does not do or are difficult for my child? In what activities or skill areas does my child need considerable support and/or practice? | HOW DOES MY CHILD'S DEVELOPMENT RELATE TO HIS/HER SAME-AGE PEERS? |
|---|---|---|---|---|
| **DEVELOPING POSITIVE SOCIAL-EMOTIONAL SKILLS** | *****Attend to people?<br>*****Relate with family members, other adults and children?<br>*Express an array of emotions?<br>*Manage emotions?<br>*Recognize and respond to verbal and nonverbal cues?<br>*Show empathy?<br>*Demonstrate attachment and independence? | _____ | _____ | **Entry #** — **Exit #** —<br>Has my child shown any new skills or behaviors related to positive social-emotional development?<br>**Check one:**<br>**Yes** ☐ (include as strengths)<br>**No** ☐ **N/A** ☐ |
| **ACQUIRING AND USING KNOWLEDGE AND SKILLS** | *Understand and respond to basic concepts, directions and/or requests?<br>*Think, remember, reason, problem solve, and communicate?<br>*Interact with books, pictures?<br>*Engage in pretend play?<br>*Manage sensory information?<br>*Use their body? | _____ | _____ | **Entry #** — **Exit #** —<br>Has my child shown any new skills or behaviors related to acquiring and using knowledge and skills?<br>**Check one:**<br>**Yes** ☐ (include as strengths)<br>**No** ☐ **N/A** ☐ |
| **TAKING APPROPRIATE ACTION TO MEET NEEDS** | *Take care of his/her basic needs, such as feeding and dressing?<br>*Move his/her body from place to place?<br>*Use his/her hands to play with toys and use crayons?<br>*Communicate wants and needs?<br>*Contribute to his/her own health and safety? | _____ | _____ | **Entry #** — **Exit #** —<br>Has my child shown any new skills or behaviors related to taking actions to meet needs?<br>**Check one:**<br>**Yes** ☐ (include as strengths)<br>**No** ☐ **N/A** ☐ |

Adopted from MD IFSP Part 3-A Dev_06/11
March 2017 – Family Centered Early Supports and Services NH/Part C

Child's Name: _____ Date of Birth: _____ Date of IFSP meeting: _____

## IFSP CHILD/FAMILY OUTCOME

| |
|---|
| **Outcome:** The child and/or family will be able to…<br>_____ |
| **Measurement:** We will know this outcome has been achieved when…<br>_____ |
| S**trategies** that can be included into the child and family's everyday routines and activities:<br>_____ |
| The family is the lead for implementing these strategies with the support from the IFSP team.<br><br>(Responsible provider(s) name and credentials) _____ will focus on strategies within the natural environment.<br><br>The family has identified the natural environment(s) to include: _____ |

This outcome was originally developed: _____ Expected date of completion: _____

| |
|---|
| **Six Month Review** Summary (modifications, revisions, completion):<br>**Date: _____**<br>_____<br><br>**Parent initials: _____** |

Child's Name: _____ Date of Birth: _____ Date of IFSP meeting: _____

**IFSP SUPPORTS and SERVICES** (to help child and family reach outcomes)

| **Specific FCESS Service to be Provided** | **How This Will Be Provided (Method)** | **How Often (Frequency)** | **How Long Each Time (Intensity/Length)** | **Where This Will Be Done (Location)** | **Projected Start Date** | **Projected End Date** | **Actual End Date** |
|---|---|---|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| **Service Coordination** will be provided at least once a month to assist and enable a child and the child's family to receive services (coordinate services across agency lines) and rights, including procedural safeguards, required under Part C IDEIA, HeM510, and HeM203. | | | | | | | |
| **FCESS FUNDING SOURCE:** Medicaid ☐ Private Insurance ☐ FCESS funds (federal/state) ☐ (Check all that apply) | | | | | | | |

**Natural Environment Statement**

*Each service is provided to my child in the natural environment to the maximum extent appropriate.

**Yes ☐ No ☐ (check one)**

| *If any support/service cannot take place in our child's natural environment, the reason why and the plan for moving them back to our child's natural environment, including timelines. | | |
|---|---|---|
| **Service** | **Justification** | **Timeline** |
| _____ | _____ | _____ |

**Other Supports or Services being accessed by the family**: (community services, medical, therapies, etc.)

**Who would you like us to coordinate with? _____**

| Other support or service (characterized as 'non FCESS driven' "Identified by the family") | How will this be funded or how we will attempt to access this support/service through a public or private source |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Child's Name: _____ Date of Birth: _____ Date of IFSP meeting: _____

## TRANSITION PLAN

| **Transition Steps and Services** | **Will we do it?** (Yes/No) Check one | **Who will do it?** | **When do we expect to do it?** | **When did we do it?** |
|---|---|---|---|---|
| Transition plan initiated at IFSP meeting | YES☐ NO☐ | IFSP Team | 27-32 months of age | _____ |
| Determination of potentially eligible for preschool special education | YES☐ NO☐ | IFSP Team | 27-32 months of age | _____ |
| Family given option to "opt out" of notification/referral for special education services | YES☐ NO☐ Families can change their decision at any time | IFSP Team | 27-32 months of age | _____ |
| If potentially eligible, written notification/referral made to special education | YES☐ NO☐ Families can change their decision at any time | FCESS Program | Within 7 days of family signature | _____ |
| If appropriate, referral to community services | YES☐ NO☐ What would you like to know more about? | Service Coordinator | Continuous Process | _____ |
| Training opportunities for parents | YES☐ NO☐ What would you like to know more about? | Service Coordinator | Continuous Process | _____ |
| Transition Conference with family, ESS, school, others as appropriate **at least 90 days prior to child's 3rd birthday** | YES☐ NO☐ FCESS will coordinate the Transition Conference | IFSP Team | 27-32 months of age | _____ |
| Submit request to have AA eligibility determined | YES☐ NO☐ FCESS will coordinate the process | Service Coordinator | 33 months of age | _____ |
| Eligibility for AA services determined | FCESS does not determine eligibility | Area Agency | Before 36 months of age | _____ |

I participated in the development of this plan on _____.
(DATE)

Parent/Guardian _____ Date ___/___/___

Service Coordinator _____ Date ___/___/___

IFSP Team Member _____ Date___/___/___

**Transition Notes:**
_____

Child's Name: _____ Date of Birth: _____ Date of IFSP meeting: _____

# PARENT/GUARDIAN CONSENT

## Parent/Guardian should initial all that apply

**Not Eligible/Not Enrolling**

_____ I received written prior notice of the evaluation and assessment.

_____ I understand my child was found **not** eligible for FCESS through a multidiscipline assessment and that I have the right to dispute these findings according to page 7 of the "Know Your Rights!" booklet provided.

_____ I understand my child was found eligible for FCESS; however I have **declined services** at this time.

**Eligible**

_____ I received written prior notice of the evaluation and assessment.

_____ I received written prior notice of the IFSP team meeting.

_____ I have taken part in developing this IFSP and understand everything in it. I understand I can accept or refuse any or all of the supports/services in this plan.

_____ I **accept** the supports/services in this IFSP.

_____ I **do not accept** the following supports/services in this IFSP (Please list): _____

_____ The following supports/services may take place while we discuss our disagreements (Please list): _____

_____ At the time of signing this IFSP, I understand and agree that the individual provider(s) are not yet identified on the outcome(s) page(s). The individual provider(s) will contact me within 14 calendar days of signing this IFSP.

_____ I understand the individual responsible for coordinating the supports and services identified will be the Interim Service Coordinator identified here until a Primary Service Coordinator is identified. (Provide name and contact information) _____

_____ I have been given a copy of the Know Your Rights! booklet and my rights have been explained. This booklet includes information about my rights including the use of insurance to pay for FCESS. I understand that I can ask for help with any of the information in the booklet.

_____ I consent to my private insurance being billed for the services listed in this IFSP.

_____ I understand that my Medicaid will be billed for services.

**"It is the responsibility of the parent to notify FCESS of changes in insurance coverage"**

_____ **Date** ___/__/___

**Parent/Legal Guardian Signature**

_____ **Date** ___/__/___

**Parent/Legal Guardian Signature**