



Early On Washtenaw Coordinated Individual Family Service Plan

Name: Last First Middle
Birth Date: Age: Gender: Male Female Student UIC:
Address of child: City: Zip Code:
Resident District: Child's City of Birth:

Ethnic: American Indian/Alaska Native Asian/Asian American Black/African American
Hispanic Yes No Native Hawaiian/Other Pacific Islander White/Middle Eastern

Name of Parent/Guardian: Relationship to Child:
Address: City: State: Zip Code:
Home Phone: Other Phone: Email:

Name of Parent/Guardian: Relationship to Child:
Address: City: State: Zip Code:
Home Phone: Other Phone: Email:

Our Preferred Language Is: *If in Foster Care, Birth Parent must be listed

REFERRAL INFORMATION

Date of Referral: Consent to Evaluate Date: Referred By:

First IFSP Meeting Date: Initial IFSP Completion Date: 30 Day Placement:
Day 45 - Evaluation completed Day 60 - Signatures received

Special circumstances for not meeting 45 or 60 day timeline: Reason Required

Additional Information:

6 Month Review (or earlier): Interim IFSP:
Annual IFSP: Transition - from 2 years, 3 months to 2 years, 9 months:

Combined IFSP/Eligible IEP Yes No Exit Date (Must attach Exit Form):

ELIGIBILITY

Eligibility for Early On

(Must check one)

Yes No
Move from Michigan Special Education Services

Established Condition: Primary:
Established Condition: Secondary:
Developmental Delay: Primary:
Percentage:
Developmental Delay: Secondary:
Percentage:

Other/Comments:
Service Coordinator:

Agency: Address:

Eligibility for Michigan Special Education Services (Must check one)

Yes No Not Evaluated
Move from Early On Part C

Referral Date:
Consent for Special Education Evaluation:

Primary Eligibility:
Secondary Eligibility:

IEP Date: MET Date:
Phone:

EVALUATION

Must include all the following: the results of developmental assessments, developmental history, health status and observation of parent and child.

PRESENT LEVEL OF DEVELOPMENT

Area	Family Input	Priority of Family	Current Findings (Include method and/or evaluation instruments)	Name Title Date of Assessment
Health & Medical (Including Vision & Hearing)		#	Physician Health Status Form requested on (date): _____ Results showed: <input type="checkbox"/> No physical health concerns <input type="checkbox"/> Concerns raised: _____ <input type="checkbox"/> Physician did not return information by IFSP date Hearing Test by Vision Test by Physician (name): Physician (name): _____ _____ On (date): _____ On (date): _____ Results showed: Results showed: <input type="checkbox"/> No concerns <input type="checkbox"/> No concerns <input type="checkbox"/> Concerns raised: <input type="checkbox"/> Concerns raised: _____ _____ Early On Hearing Early On Vision Checklist administered Checklist administered on (date): _____ on (date): _____ <input type="checkbox"/> Child passed and <input type="checkbox"/> Child passed and results showed no reason results showed no reason for further testing for further testing <input type="checkbox"/> Checklist identified <input type="checkbox"/> Checklist identified cause for concern: cause for concern: further hearing testing further vision testing for _____ for _____ did/will occur did/will occur	
Movement (Fine/Gross Motor)		#		
Understanding & Expression (Communication)		#		
Thinking & Learning (Cognitive)		#		
Relationships & Interactions (Social/Emotional)		#		
Doing Things for Him/Herself (Adaptive/Self-Help)		#		
Parent/Guardian Child Interaction (Observable Relationships)		#		

Attach Evaluation Reports

FAMILY NEEDS AND PRIORITIES

Complete only if the family has given permission for an interview on the *Consent to Evaluate Form*.

Name: Last _____ First _____ Middle _____

Person Interviewed: _____ Date of Interview: _____

Tell me about your child, how would you describe him or her:

- | | | | | |
|-------------------------------------|--|---------------------------------------|--|---|
| <input type="checkbox"/> Playful | <input type="checkbox"/> Affectionate | <input type="checkbox"/> Calm | <input type="checkbox"/> Fearful or shy | <input type="checkbox"/> Demanding |
| <input type="checkbox"/> Overactive | <input type="checkbox"/> Hot tempered | <input type="checkbox"/> Confident | <input type="checkbox"/> Reckless | <input type="checkbox"/> Hard to handle |
| <input type="checkbox"/> Happy | <input type="checkbox"/> Sad | <input type="checkbox"/> Worried | <input type="checkbox"/> Unusually sensitive | <input type="checkbox"/> Stubborn |
| <input type="checkbox"/> Curious | <input type="checkbox"/> Likes People | <input type="checkbox"/> Fearless | <input type="checkbox"/> Joyful | <input type="checkbox"/> Good Disposition |
| <input type="checkbox"/> Angry | <input type="checkbox"/> Hard to Comfort | <input type="checkbox"/> Other: _____ | | |

What is your child's typical day like, who is he/she usually with, what does he/she play with, and what are meal times/bath times/dressing times like?

On most days, what part of the day is the most enjoyable? The most difficult?

How does your child get along with people? With you? With others?

Is there anything about your child that worries you?

I want to know more about: (Check all that apply)

- Meeting with other families to share information, or to learn about a child like mine
- Finding or working with doctors or other specialists
- Planning for the future; what to expect
- People who can help me at home or care for my child so I/we can have a break
- Information on my child's disability, what it means
- Resources to help defray costs of my child's special needs (e.g., equipment, supplies, other)
- Housing, clothing, jobs, education, food, telephone, transportation
- Other: _____
- None of the Above

I want help for my child in the following area(s): (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Getting around | <input type="checkbox"/> Talking and listening |
| <input type="checkbox"/> Thinking, learning, playing with toys | <input type="checkbox"/> Feeding, eating, nutrition |
| <input type="checkbox"/> Having fun with other children | <input type="checkbox"/> Behaviors & feelings (constant crying, he doesn't like to be held, doesn't look at me) |
| <input type="checkbox"/> Bathing, getting dressed, bed time | <input type="checkbox"/> Sleeping |
| <input type="checkbox"/> Calming down, quieting down | <input type="checkbox"/> Other |
| <input type="checkbox"/> Seeing or hearing | |
| <input type="checkbox"/> None of the Above | |

Early On Washtenaw Coordinated Individual Family Service Plan

GOALS/OUTCOMES/REVIEW

Name: Last _____ First _____ Middle _____
 Date: _____ Initial 6 Month Review Annual Review
 30 Day Placement Interim Transition Other Review

Review of Outcomes must be conducted at least every six months OR more frequently if the family requests a review to determine the degree of progress toward achieving outcomes and whether modifications or revision of the outcomes or services is necessary.

Present Status – What is happening now?

GOAL(S)/OUTCOME(S) STATEMENT: Outcome # Related to Family Priority #
A – Audience (Person targeted); **B** – Behavior (Procedures to be used); **C** – Criteria; **D** – Duration (Time Line)

Steps/Objectives – To reach this outcome. For each Special Education goal list at least 2 short term objectives to meet each goal.	Expected Time Frame
Strategies/Methods – for working on this outcome during this child & family’s daily routines and activities.	People to be involved

Date for reviewing the progress made on this outcome (must be within 6 months of the date written):	
REVIEW OF OUTCOME(S)	
Progress Summary: (What has changed since the outcome was last written or reviewed?)	
Modifications/Revisions: (What changes need to be made with this Outcome?)	
<input type="checkbox"/> I participated in the review of this outcome Parent Signature:	Date:

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Services

Name: Last _____ First _____ Middle _____

Date: _____ Initial 6 Month Review Annual Review
 30 Day Placement Interim Transition Other Review

* Prim Serv	Service/ Provider	Supports Outcome(s) #	Frequency (How often?) Intensity (How long?)	** (I) (G)	Start Date	End Date	Actual Begin Date	*** Setting/ Location	Payor	Parent Initials
<input type="checkbox"/>										
<input type="checkbox"/>										
<input type="checkbox"/>										
<input type="checkbox"/>										
<input type="checkbox"/>										
<input type="checkbox"/>										

* Must Select 1 (only) as Primary Service

** Individual (I) Group (G)

*** H – Home CB – Community Based O – Other (indicate why service cannot be met in the natural environment)

If any service cannot be met in the natural environment with supplementary supports explain why it cannot be met there and the timeline for its inclusion into the child’s natural environment.

OTHER SERVICES

To the extent appropriate, the IFSP must document services that are not required or covered under Part C. Listing the non-required services does not mean that those services must be provided, however, their identification can be helpful to both the family and the service coordinator to assist in securing those services, including those through public or private sources. These services must correspond to family identified outcomes.

Service	Outcome #	Start Date Mo/Day/Yr	End Date Mo/Day/Yr	Duration/ Frequency/ Intensity	Provider Information	Location/ Setting	Funding Source

Early On Washtenaw Coordinated Individual Family Service Plan Transition

Name: Last: _____ First: _____ Middle: _____ DOB: _____
 Parent/Guardian Name: _____
 Service Coordinator Name: _____
 Transition Period Dates: 2 years, 3 months _____ 2 years, 9 months _____ 3rd Birthday _____

Transition Plan Meeting Date: _____
 (Must match parent signature date)

STEPS & SERVICES TO SUPPORT THE TRANSITION OF THE CHILD

Discussion with parents regarding future placements of their child. (include at least 2 options)
 1. _____ 2. _____ 3. _____ 4. _____

Procedures to prepare the child for changes in service delivery, including steps to help the child adjust to a new setting.
 Prepare a visit to a potential program.
 Explore other community resources.
 Other: _____

Strategies that will be used to address the above steps: (the first 2 must be addressed)

TRANSITION CONFERENCE

The Transition Planning Conference must take place at least 90 days, but not prior to nine months, before the child's third birthday, for any child who may be transitioning to Special Education services.

Transition Conference Date: _____

In attendance:

Parent Signature: _____
 Service Coordinator Signature: _____
 Lead Agency Signature: _____
 LEA Representative Signature: _____

Expected Transition Date: _____
IEP Date (if appropriate) _____

REASON FOR TRANSITION

Child reached 3rd birthday
 Child no longer meets definition of eligibility for *Early On*[®]
 Parent no longer wants services
 Family has moved
 Unable to contact family
 Other: _____

CHILD'S PRESENT LEVEL OF DEVELOPMENT

Transition Needs:
(check all that need to be addressed)

Health

- Vision/Hearing
- Gross Motor
- Fine Motor
- Communication
- Thinking Skills
- Social/Emotional
- Adaptive

Updated Evaluations: (include results, instrument(s) used, date, and evaluator(s))

Present Eligibility for Special Education: (Check one) Eligible Potentially Eligible Not Eligible

Services that will end at my *Early On* Transition date:

Service	How Long/How Often	Location	End Date	Parent Initial

Services that will continue beyond my *Early On* Transition date:

Service	How Long/How Often	Location	End Date	Parent Initial

Signature & Procedural Safeguards

(This signature page is to be used with every IFSP or IEP development or change.
Check the "Type of IFSP/ IEP to indicate the purpose of this page.)

Child's Legal Name: _____ Date: _____

TYPE OF IFSP OR IEP	
<input type="checkbox"/> Initial IFSP Date: _____ <input type="checkbox"/> Completed IFSP Date: _____ <input type="checkbox"/> 6 Month Review/Date: _____ <input type="checkbox"/> Annual IFSP and/or IEP/Date: _____	<input type="checkbox"/> Other Review/Date: _____ <input type="checkbox"/> Interim IFSP _____ <input type="checkbox"/> Transition Conference/Date: _____ <input type="checkbox"/> Transition/Date: _____

TEAM MEMBERS AND CONTRIBUTORS		
Printed Name/Signature	Role/Agency	Phone/email

PARENT CONSENT (Please check all that apply)
<input type="checkbox"/> I/We as parent(s)/guardian(s), have had <i>Early On</i> [®] and/or Special Education explained to me/us including my/our rights and the possibility of participation in an evaluation survey. <input type="checkbox"/> I/We have helped to develop this plan. <input type="checkbox"/> I/We understand and agree with its content. <input type="checkbox"/> I/We agree to each of the services I/we have initialed. <input type="checkbox"/> I/We have received a copy of the: <input type="checkbox"/> <i>Welcome to Early On Guidebook</i> <input type="checkbox"/> <i>Family Rights Guidebook</i> <input type="checkbox"/> <i>Transition Guidebook</i> <input type="checkbox"/> <i>The Individualized Family Service Plan Guidebook</i> <input type="checkbox"/> <i>Procedural Safeguards for Special Education</i> OR <input type="checkbox"/> I/We do not agree with this IFSP or IEP. <input type="checkbox"/> I/We decline <i>Early On</i> [®] services.

DISPOSITION OF <i>EARLY ON</i> [®] RECORDS
The following ✓ indicates the disposition of the child's Early On Record: <input type="checkbox"/> A copy will be forwarded to the receiving program/service provider. Name _____ <input type="checkbox"/> Complete IFSP record, with supportive documentation on file with: Agency: _____ <input type="checkbox"/> The record will be maintained for a minimum of 7 years as required by law. <input type="checkbox"/> After the 7 year holding period you have my permission to physically destroy the records.

Parent Signature: _____
 Service Coordinator Signature: _____

Date: _____
 Date: _____

Special Educational Accommodations, Modifications and Considerations

(To be completed for IEP's only)

Child's Legal Name: _____ Date: _____

The IEP/IFSP Team has considered supplementary aids and services, program modifications, and supports for school personnel required for the child to attain the annual goals. The Team considered accessibility of physical facilities, specialized transportation, assistive technology devices, & assistive technology services.

Service	Frequency/Duration/Condition	Initial Date	Duration Date	Location

This IFSP/IEP Team considered the need for a teacher endorsed in a particular category.

How will the developmental needs of this child be addressed during the summer months? _____

IEP/IFSP TEAM RECOMMENDATION

- This child is **Not eligible** for special education programs/services.
- Outlines programs/services to be provided with the following **person assuring implementation:** _____
- All programs/services/modifications will begin on _____ end on _____ and continue for: *(choose one)*
- One regular school year An adapted school year
- Other: (Specify) _____ Rationale: _____
- One or more IEP/IFSP Team Members disagree with this recommendation. *(Complete & attach a dissenting report)*

IEP/IFSP COMMITMENT SIGNATURES

Resident District

The resident district assures that the least restrictive/natural environment has been fully considered and: *(choose all that apply)*

- Agrees** with the recommendation of the IEP/IFSP Team and: *(check all that apply for eligible children)*
- Assigns** this child to the following: program/school & operating district: _____
- Authorizes** the non-resident district to assign an appropriate school/program and conduct post-initial IEP/IFSP Team meetings.
- Does not agree** with the recommendation of the IEP/IFSP Team

Resident District Superintendent/Designee: _____ Date: _____

Operating District

The non-operating district assures that the least restrictive/natural environment has been fully considered and: *(choose all that apply)*

- Agrees** with the recommendation of the IEP/IFSP Team and: *(check all that apply for eligible children)*
- Assigns** this child to the following program/school & operating district: _____
- Authorizes** the non-resident district to assign an appropriate school/program and conduct post-initial IEP/IFSP Team meetings.
- Does not agree** with the recommendation of the IEP/IFSP Team

Operating District Superintendent/Designee: _____ Date: _____

Parent/Guardian

I, as parent/guardian, have had *Early On*[®] and Special Education explained to me, have helped to develop this plan & understand its contents, have received a copy of & understand my Procedural Safeguards *(check all that apply)*

- I Authorize** the sharing of information with agencies that will implement this plan.
- I Agree** to the content and implementation of this plan, and its referrals
- I Do not agree** with the IEP/IFSP

Parent/Guardian: _____ Date: _____

Parent/Guardian: _____ Date: _____

Parent/Guardian did not attend. Report copy was sent by: _____ Date: _____