



MISSOURI  
DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION  
First Steps Early Intervention Program  
**Individualized Family Service Plan (IFSP)**

IFSP Date IFSP Type IFSP Period:
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**Section 1- A: Child Information**

Child's Name	Date of Birth / /	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
AKA Name	Child ID	MOSIS ID
County	School District	

**Section 1 - B: Family Contact Information**

Primary Contact Name	Relationship to child:
Mailing Address	<input type="checkbox"/> Phone
Physical Address	Language:
Other Contact:	Relationship to the child:
Mailing Address	<input type="checkbox"/> Phone

**Section 1-C: First Steps Contact Information**

Service Coordinator	Agency Name
Address	Phone
Primary Provider	Agency Name
Email Address	Phone

**Section 1-D: Getting to Know Your Family**

Who is included in your family? \_\_\_\_\_

What is your favorite time/activity with your child? \_\_\_\_\_

What is the best time of day for your family? \_\_\_\_\_

What is your family's most challenging time of day? \_\_\_\_\_

What does your family like to do together? \_\_\_\_\_

What activities would your family like to participate in? \_\_\_\_\_

Who are the important people in your family's life? \_\_\_\_\_

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Where does your family usually spend time during the week? \_\_\_\_\_

Where does your family usually spend time on the weekends? \_\_\_\_\_

Is your family enrolled in PAT?  Y  N If yes, who is your Parent Educator: \_\_\_\_\_

Does your child attend child care?  Y  N

Attendance Days:  M  T  W  Th  F  Sa  Su Hours: \_\_\_\_\_

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

**Section 2: Health and Medical (including vision and hearing)**

**General Health Information**

**Primary Reason for Eligibility in First Steps**

**Physicians**

Primary Care Physician Name	Address/Phone
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Other Physician or Specialist	Address/Phone
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**Hearing Information**

Child has had a hearing test  Yes  No  
 (If yes) Date of exam: \_\_\_\_\_  
 Doctor Name: \_\_\_\_\_

Results:  Pass  Fail  
 Follow-up needed  Unsure

Has the child passed the Newborn Hearing Screening?  
 Yes  No  Unknown

**Vision Information**

Child has had a vision test  Yes  No  
 (If yes) Date of exam: \_\_\_\_\_  
 Doctor Name: \_\_\_\_\_

Results:  Pass  Fail  
 Follow-up needed  Unsure

**Family History of Permanent Childhood Hearing Loss?**

Parent / Caregiver concern or observation

**Family History of Eye Conditions (other than glasses)?**

Parent / Caregiver concern or observation

**Section 3: Present Levels of Development in Daily Routines and Activities**

Routine	Task Difficulty	Activity	Developmental Areas
Wake Up	<input type="checkbox"/> Easy <input type="checkbox"/> Some Concerns <input type="checkbox"/> Difficult	What's working well:   What's not working well:	<input type="checkbox"/> Communication <input type="checkbox"/> Movement/ Physical <input type="checkbox"/> Learning/ Cognition <input type="checkbox"/> Social/ Emotional/ Behaviors <input type="checkbox"/> Self-help/ Adaptive

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Routine	Task Difficulty	Activity	Developmental Areas
Dressing / Toileting	<input type="checkbox"/> Easy <input type="checkbox"/> Some Concerns <input type="checkbox"/> Difficult	What's working well:   What's not working well:	<input type="checkbox"/> Communication <input type="checkbox"/> Movement/ Physical <input type="checkbox"/> Learning/ Cognition <input type="checkbox"/> Social/ Emotional/ Behaviors <input type="checkbox"/> Self-help/ Adaptive
Mealtime	<input type="checkbox"/> Easy <input type="checkbox"/> Some Concerns <input type="checkbox"/> Difficult	What's working well:   What's not working well:	<input type="checkbox"/> Communication <input type="checkbox"/> Movement/ Physical <input type="checkbox"/> Learning/ Cognition <input type="checkbox"/> Social/ Emotional/ Behaviors <input type="checkbox"/> Self-help/ Adaptive
Outings	<input type="checkbox"/> Easy <input type="checkbox"/> Some Concerns <input type="checkbox"/> Difficult	What's working well:   What's not working well:	<input type="checkbox"/> Communication <input type="checkbox"/> Movement/ Physical <input type="checkbox"/> Learning/ Cognition <input type="checkbox"/> Social/ Emotional/ Behaviors <input type="checkbox"/> Self-help/ Adaptive
Play	<input type="checkbox"/> Easy <input type="checkbox"/> Some Concerns <input type="checkbox"/> Difficult	What's working well:   What's not working well:	<input type="checkbox"/> Communication <input type="checkbox"/> Movement/ Physical <input type="checkbox"/> Learning/ Cognition <input type="checkbox"/> Social/ Emotional/ Behaviors <input type="checkbox"/> Self-help/ Adaptive
Bathtime	<input type="checkbox"/> Easy <input type="checkbox"/> Some Concerns <input type="checkbox"/> Difficult	What's working well:   What's not working well:	<input type="checkbox"/> Communication <input type="checkbox"/> Movement/ Physical <input type="checkbox"/> Learning/ Cognition <input type="checkbox"/> Social/ Emotional/ Behaviors <input type="checkbox"/> Self-help/ Adaptive
Bedtime/ Naps	<input type="checkbox"/> Easy <input type="checkbox"/> Some Concerns <input type="checkbox"/> Difficult	What's working well:   What's not working well:	<input type="checkbox"/> Communication <input type="checkbox"/> Movement/ Physical <input type="checkbox"/> Learning/ Cognition <input type="checkbox"/> Social/ Emotional/ Behaviors <input type="checkbox"/> Self-help/ Adaptive

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Routine	Task Difficulty	Activity	Developmental Areas
Other Routine	<input type="checkbox"/> Easy <input type="checkbox"/> Some Concerns <input type="checkbox"/> Difficult	What's working well:   What's not working well:	<input type="checkbox"/> Communication <input type="checkbox"/> Movement/ Physical <input type="checkbox"/> Learning/ Cognition <input type="checkbox"/> Social/ Emotional/ Behaviors <input type="checkbox"/> Self-help/ <input type="checkbox"/> Adaptive

**Section 4: Family Assessment**

The family chooses to share information about their concerns, priorities and resources and/or include this information in the IFSP. The family understands that if their child is eligible, s/he can still receive services if they do not complete this section.  
 The family gave permission?  
 Yes  No Date: \_\_\_\_\_

What are the family's concerns?  
  
 Of the concerns, what would the family like to focus on (priorities)?  
  
 What resources does the family use?

**Section 5: Outcomes**

Child Outcome # \_\_\_\_\_

\_\_\_\_\_ will \_\_\_\_\_ by \_\_\_\_\_. We will know \_\_\_\_\_ can do this when \_\_\_\_\_.

**Strategies and Activities:** (Include activity settings, people, and everyday routines of the child and family).  
  
 \_\_\_\_\_

How does the team plan on measuring progress? <input type="checkbox"/> Provider progress notes <input type="checkbox"/> Parent report <input type="checkbox"/> Service Coordinator contact with family	When will progress toward the outcome be measured? <input type="checkbox"/> Each week <input type="checkbox"/> Monthly <input type="checkbox"/> 6 month review
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<b>Outcome review date</b> _____	Modification to Outcome <input type="checkbox"/> Yes <input type="checkbox"/> No
	Outcome Status <input type="checkbox"/> Continue with Changes <input type="checkbox"/> Continue as written <input type="checkbox"/> Discontinue
	Summary of Progress _____

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Family Outcome # \_\_\_\_\_

**Strategies and Activities:** What strategies will we work on together toward this outcome?

How does the team plan on measuring progress?

- Provider progress notes
- Parent report
- Service Coordinator contact with family

When will progress toward the outcome be measured?

- Each week
- Monthly
- 6 month review

**Outcome review date**  
\_\_\_\_\_

Modification to Outcome

- Yes
- No

Outcome Status

- Continue with Changes
- Continue as written
- Discontinue

Summary of Progress

**Section 6: Services and Supports Needed to Achieve Outcomes**

Service Type/ Method/ Intensity	To help with Outcome	Location	Frequency/Length	Provider Name	Funding Source	Duration

**Primary Setting for Services (Most services occur here):** \_\_\_\_\_

**Section 7: Natural Environment**

Outcome #	Service	Why Service Cannot be Provided in Natural Environment	How the Intervention will be Generalized into Child's and Family's Daily Activities	The Plan to Move Intervention into a Natural Environment

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Section 8: Other Services and Supports**

Service	Description	Person Responsible	Steps to Assist	Start and End Dates

**Section 9: Team Communications**

**Section 10: Transition**

Anticipated Date of Transition: \_\_\_\_\_

Transition Topic	Transition Activities
1. Discussion with parent regarding what "Transition" from Early Intervention means.	
2. Dates the directory information and IFSP/evaluation/assessment sent to LEA or date parent opted out.	
3. Discuss Transition Plan, including options, steps and services to help prepare for a new setting.	
4. Discuss Transition Conference include C and B differences, LEA contact info and eligibility process.	
5. Other transitions or changes for the family.	
6. Summer 3 <sup>rd</sup> Birthday: discuss school readiness including reading, language and counting skills.	

**Section 11: Attendance**

IFSP MEETING TYPE:		IFSP MEETING DATE:		
Name	Agency	Phone Number	Role	Method of Attendance