



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

IFSP Type
IFSP Date

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 child:
Mailing Address	<input type="checkbox"/> Phone

Section 1-C: First Steps Contact Information		
Service Coordinator	Agency Name	
Address	Phone	
Primary Provider	Agency Name	
Address	Phone	

Section 2: Family Assessment
<p>I choose to share information about my concerns, priorities and resources and/or include this information in the IFSP. I understand that if my child is eligible, he/she can still receive services if I do not complete this section. Family permission? <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Date: _____</p>

<p>Things I want to share:</p> <p>I am most proud of:</p> <p>My child is good at:</p> <p>My child's favorite objects or toys are:</p> <p>My child's favorite foods are:</p> <p>My child's favorite people or playmates are:</p> <p>Please Beware! My child does not like:</p> <p>I know my child feels happy when:</p> <p>I know my child feels frustrated when:</p> <p>I know what my child wants (food, sleep, diaper change, toy) when:</p> <p>My child gets upset when:</p> <p>I calm my child down by:</p>
--

<p>What's on My Mind:</p> <p>Right now, my biggest questions are about:</p>
--

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

I worry about:

I would like your help with:

Places We Go:

During the week my child is usually at the following place(s):

Morning:

Afternoon:

Evening:

Other places my child goes with me or others:

When I need help I call:

Important people in our life:

Community resources we use:

Enrolled in Child Care: Y N Attendance Days: M T W Th F Sa Su Hours:

Provider : Location:

Section 3: Health and Medical (including vision and hearing)

General Health Information. *Include concerns, new diagnoses, serious illnesses or accident, seizures, hospitalizations, and medications.*

Primary Reason for Eligibility in First Steps

Physicians

Primary Care Physician Name	Address/Phone
Other Physician or Specialist	Address/Phone

Hearing Information	Vision Information
----------------------------	---------------------------

Child has had a hearing test <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes) Date of exam: Doctor Name: Doctor Address: Results: <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Follow-up needed <input type="checkbox"/> Unsure Has the child passed the Newborn Hearing Screening? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Child has had a vision test <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes) Date of exam: Doctor Name: Doctor Address: Results: <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Follow-up needed <input type="checkbox"/> Unsure
--	---

RISK FACTORS FOR HEARING LOSS	RISK FACTORS FOR VISION LOSS
These are family and medical history details for infants and toddlers who are at risk of late onset or progressive hearing loss.	These are family and medical history details that have a high incidence of vision loss in infants and toddlers.

<input type="checkbox"/> Family history of permanent childhood hearing loss <input type="checkbox"/> Premature birth of 36 weeks or less <input type="checkbox"/> Medical history of infection or trauma <input type="checkbox"/> Post natal infection; such as bacterial meningitis <input type="checkbox"/> Recurrent/persistent otitis media (ear infection) for at least 3 months <input type="checkbox"/> Eustachian tube dysfunction <input type="checkbox"/> Medical condition associated with hearing loss <input type="checkbox"/> Child does not respond to name when called <input type="checkbox"/> Child does not react to loud noises or toys with noise <input type="checkbox"/> Child stands near objects (i.e., radio) to hear sound Parent / Caregiver concern or observation	<input type="checkbox"/> Family history of eye condition (other than glasses) <input type="checkbox"/> Premature birth of 36 weeks or less <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Does not notice people or objects when placed in certain areas <input type="checkbox"/> Eyes make constant, quick movements or appear to have a shaking movement <input type="checkbox"/> Brings objects to one eye rather than using both eyes to view <input type="checkbox"/> Covers or closes one eye frequently If child is older than 6 months: <input type="checkbox"/> Tilts or turns head to one side while looking <input type="checkbox"/> Cannot see a dropped toy <input type="checkbox"/> Eyes appear to turn inward, outward, upward or downward <input type="checkbox"/> Responds to toys only when there is an accompanying sound <input type="checkbox"/> Moves hand or object back and forth in front of eyes <input type="checkbox"/> Consistently over or under reaches <input type="checkbox"/> Squints, frowns or scowls when looking at objects Parent / Caregiver concern or observation
--	--

Section 4: Present Levels of Development in Daily Routines and Activities

Routine	Task	Activity	Developmental Areas
---------	------	----------	---------------------

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

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

Section 5: Outcomes

Child Outcome # _____

(child name)_____ will (participate in routine)_____ by (actions and specific behaviors)_____. We will know (child name)_____ can do this when (Measurable criterion and generalization/maintenance/fluency/time)_____.

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

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

Child's Name _ Date of Birth ___/___/___

IF REVIEW: Outcome review date _____	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	

<input type="checkbox"/> Family Outcome # _____		
Family Outcome Statement and Criteria: _____		
Strategies and Activities: What strategies will we work on together toward this outcome?		
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	
IF REVIEW: Outcome review date _____	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 ___/___/___

Section 6: Services and Supports Needed to Achieve Outcomes

Service Type	To help with Outcome #s	Location	Method Group or Individual	Frequency	Duration	Intensity	Provider Name	Funding Source	Start Date	End Date

Primary Setting for Services (Most services occur here): _____

Section 7: Natural Environment

Outcome #	Service	1. Discuss Why Service Cannot be Provided in Natural Environment	2. Describe How the Intervention will be Generalized into Child's and Family's Daily Activities.	3. Identify Steps for a Plan to Move Intervention into a Natural Environment.

Section 8: Other Services and Supports

Service Description	Start Date	End Date	Person Responsible	Funding Source

Section 9: Team Communications

Section 10: Transition

Anticipated Date of Transition:

Transition Topic	Transition Activities	Date	Person Responsible
1. Discuss with parents what "Transition" from Early Intervention" means			
2. Inform school district of child's potential eligibility and provide directory information			
3. Discuss preschool special education as well as other community program options for the child.			
4. Send specified information to school district and/or community programs with parental consent.			
5. With parental consent and prior notice, hold a transition			

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

meeting with all required persons to develop a transition plan.			
6. Discuss activities/supports to help the child and family prepare for a new setting			
7. Other changes in our family's life			

Section 11: Attendance

IFSP MEETING TYPE: _____
 IFSP MEETING DATE: _____

Name	Agency	Role	Method of Attendance