

**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 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

Diagnosis: _____ **Health/ Medical Information**
Medical Alerts: _____

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

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

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: _____ Phone #: (____) _____
Address _____
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.

<p>1. Functional Outcome:</p> <p>Objectives: Short term goals that should be achieved in order for the child to reach the functional outcome:</p> <p>Six Month Review: Will this outcome: <input type="checkbox"/> Continue <input type="checkbox"/> Be Revised (Complete new outcome page) <input type="checkbox"/> Discontinue Progress Note Dates:</p> <p>3. Functional Outcome:</p> <p>Objectives: Short term goals that should be achieved in order for the child to reach the functional outcome:</p> <p>Six Month Review: Will this outcome: <input type="checkbox"/> Continue <input type="checkbox"/> Be Revised (Complete new outcome page) <input type="checkbox"/> Discontinue Progress Note Dates:</p>	<p>2. Functional Outcome:</p> <p>Objectives: Short term goals that should be achieved in order for the child to reach the functional outcome:</p> <p>Six Month Review: Will this outcome: <input type="checkbox"/> Continue <input type="checkbox"/> Be Revised (Complete new outcome page) <input type="checkbox"/> Discontinue Progress Note Dates:</p> <p>4. Functional Outcome:</p> <p>Objectives: Short term goals that should be achieved in order for the child to reach the functional outcome:</p> <p>Six Month Review: Will this outcome: <input type="checkbox"/> Continue <input type="checkbox"/> Be Revised (Complete new outcome page) <input type="checkbox"/> Discontinue Progress Note Dates:</p>
<p>Signature of Person Completing <input type="checkbox"/> 6 <input type="checkbox"/> 18 <input type="checkbox"/> 30 mo Review</p>	<p>Signature and Stamp of EIOD (at Review)</p>

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 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 responsibilities:

- 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: (____) _____

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

Service Provider not identified at time of IFSP for the following services (Pending):
 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: _____
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?	13: Prescription Needed?
1: TYPE SVC Code Letter	_____	_____	_____	_____	_____	_____	_____	_____	Waiver Code(s) _____	Initial Start date: _____ <input type="checkbox"/> ADD <input type="checkbox"/> END	<input type="checkbox"/>	<input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Nursing
2: TYPE SVC Code Letter	_____	_____	_____	_____	_____	_____	_____	_____	Waiver Code(s) _____	Initial Start date: _____ <input type="checkbox"/> ADD <input type="checkbox"/> END	<input type="checkbox"/>	<input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Nursing
3: TYPE SVC Code Letter	_____	_____	_____	_____	_____	_____	_____	_____	Waiver Code(s) _____	Initial Start date: _____ <input type="checkbox"/> ADD <input type="checkbox"/> END	<input type="checkbox"/>	<input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Nursing
4: TYPE SVC Code Letter	_____	_____	_____	_____	_____	_____	_____	_____	Waiver Code(s) _____	Initial Start date: _____ <input type="checkbox"/> ADD <input type="checkbox"/> END	<input type="checkbox"/>	<input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Nursing
5: TYPE SVC Code Letter	_____	_____	_____	_____	_____	_____	_____	_____	Waiver Code(s) _____	Initial Start date: _____ <input type="checkbox"/> ADD <input type="checkbox"/> END	<input type="checkbox"/>	<input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> 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 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

TRANSPORTATION SERVICE DATA ENTRY FORM

FOR OFFICE ONLY

CHILD'S NAME:

Last _____ First _____ MI _____

EI # _____

DOB ____/____/____

DESTINATION INFORMATION

Agency name: _____

Agency EI#: _____

Site address: _____

Trans. Coord.: _____

Phone: (____) _____

Fax: (____) _____

IFSP: Initial 6-Month Annual Amended Interim

Effective date of IFSP: ____/____/____

End date of IFSP: ____/____/____

EIOD (print): _____

EIOD signature _____

Date: ____/____/____

Service Coordinator:

Name (print): _____

SC ID #: _____

Agency Name: _____

Agency #: _____

Phone: (____) _____

Fax: (____) _____

TRANSPORTATION PROVIDER INFORMATION

Transportation Provider Name: _____

Provider EI # _____

Contact person: _____

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 <input type="checkbox"/> Other <input type="checkbox"/>	Begin Date	End Date	Days per week	# Weeks	# Units (bus only)	Status
Name Companion(s):	Child	Child	M T W Th Fri Total # days per week: _____	Child	Child	<input type="checkbox"/> Add
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)	<input type="checkbox"/> End
						<input type="checkbox"/> Add
						<input type="checkbox"/> End

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

Parents/Guardians Name(s):

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 ACTIVITIES (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 EI/OD 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 EI/OD 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 (EI/OD):

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.

EI/OD STAMP:

**NYC EARLY INTERVENTION PROGRAM
CONSENT TO RELEASE/OBTAIN INFORMATION**

Child's Name: _____ EI #: _____ DOB: ___/___/___
Address: _____ Apt #: _____
City/Town: _____ State: New York Zip Code: _____

I, (Parent/Guardian's Full Name) _____, seek services for my child from the NYC Early Intervention Program. I understand that the providers (including evaluators, service providers and service coordinators) offering Early Intervention (EI) services to my child and family may need to exchange information to develop and carry out the Individualized Family Service Plan (IFSP).

(Check one)

I authorize for the information below to be released I authorize for the information below to be obtained

Specific information to be released/obtained:

EI Medical Form *Multidisciplinary Evaluation* *Supplemental Evaluation(s) Specify:* _____
_____ *Individualized Family Service Plan* *Provider Progress Notes*
 Session Notes *Other:* _____

I authorize for the information to be **(check/complete either A, B, or C):**

A. Released to all EI providers providing evaluation, service coordination, or services to my child and family

B. Released to the Individual/Agency below:

_____ (Name/ Organization)	_____ (Street Address, Borough/City, Zip Code)
(_____) _____ (Telephone Number)	(_____) _____ (Fax Number)

C. Obtained from the Individual/Agency below:

_____ (Name/ Organization)	_____ (Street Address, Borough/City, Zip Code)
(_____) _____ (Telephone Number)	(_____) _____ (Fax Number)

The information will be sent to:

_____ (Name/ Organization)	_____ (Street Address, Borough/City, Zip Code)
(_____) _____ (Telephone Number)	(_____) _____ (Fax Number)

D. The purpose of the requested information is to: (check all that apply)

- Establish Early Intervention eligibility
- Develop an Individualized Family Service Plan
- Start, coordinate and monitor Early Intervention services
- Inform the child's physician about my child's services and
- Other: _____

I understand that this release can be withdrawn at any time upon written notice to my Service Coordinator. This release ends on the date of my next scheduled IFSP (or, if sooner, specify date ___/___/___).

Signed: _____ Date: ___/___/___
Relationship to Child: _____

NOTE: A reproduced copy of this signed form is deemed to have the same force and effect as the original. A new Consent to Release Information form must be signed at the initial IFSP meeting and at each IFSP review and annual meeting. Blank consent forms should never be signed by the parent.
Consent to Release/Obtain Information Revised 12/10