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 ☐Initial ☐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			

Health/ Medical Information

Diagnosis: **Medical Alerts:**