Print Form

SUFFOLK COUNTY DEPARTMENT OF HEALTH SERVICES
BUREAU OF SERVICES FOR CHILDREN WITH SPECIAL NEEDS

INDIVIDUALIZED FAMILY SERVICE PLAN

Interim	Meeting Date
Initial	Meeting Date
Amendment	Meeting Date
6 Month Review	Meeting Date
Annual Review	Meeting Date
Transition Plan	Meeting Date

IFSP EFFECTIVE DATES FROM / / *TO* / /

To be completed at the IFSP meeting with the participation of the parent(s) and IFSP members.

Child's Name: (Last) (First) (M.I.) A.K.A.

Date of Birth: ☐ Female ☐ Male

The Legal Guardian of this child is: ☐ *Parent* ☐ *Agency* ☐ *Other Legal Guardian (SpecifY)*

Child. resides with: (Last) (First) (M.I.)

Relationship to child: ☐ Parent ☐ Fostyr Parent ☐ Guardian

Address: (Street) (City) NY (Zip Code)

Phone: (Home) Area Code Number (Work) Area Code Number

*If Child's Legal Guardian is Foster Care Agency**

Foster Placement Agency: Caseworker:

Address: (Street) (City) NY (Zip Code)

Phone: (Work) Area Code Number (Fax) Area Code Number

**Complete information page (IA) for Foster Parent, Surrogate Parent and/or other parties legally entitled to -receive documentation.*

IFSP Particiuant-s:- *Print Name* *Title/Agency* *ignature*

☐ *Parent* ☐ *Legal Guardian* ☐ *Foster Parent* ☐ *Surrogate Parent*

☐ *Agency*

☐ *Initial* ☐ *Ongoing Service Coordinator*

☐ *Evaluator* ☐ *Provider*

☐ *Early Intervention Official Designee*

☐ *Other* _____

Distribution: Bureau: White Parent: Yellow Provider: Pink Service Coordinator: Gold

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| IFSP Review
| IFSP Amendment
| Extension
| Change of OSC

SUFFOLK COUNTY
DIVISION OF SERVICES FOR CHILDREN WITH SPECIAL NEEDS
IFSP SERVICE AGREEMENT

Child's Name: _____ DOB: _____

IFSP Dates: from _____ to _____ Amended on: _____

Service Type	Rx Reqd.	Responsible Provider	Frequency / Duration	Method / Location	Start Date	End Date
Service Coordinator						

Parent/Guardian/Surrogate initials to indicate consent:

_____I have been informed of and understand my rights and entitlements under the law, my right to review, access, amend my child's record and have received a copy of "Suffolk County's Notice of Child and Family Rights".

_____ I was informed in my native language (unless clearly not feasible to do so) or other mode of communication.

_____ I have participated in the development of this IFSP.

_____ I give my consent for Suffolk County Early Intervention Program EIOD, service coordinators, evaluators and service providers to have a copy of this IFSP.

_____ I consent to the confidential exchange of information regarding my child among my child's EIOD, service coordinators, evaluators and service providers.

_____ I consent to the confidential exchange of electronic data and documents contained within NYEIS, a secure, HIPPA compliant site.

_____I understand this IFSP can be reviewed at my request.

_____ I have selected_____ as the Ongoing Service Coordinator. Phone #_____

_____ I give permission for my child's caregiver(s) _____ to review/sign (☐) provider attendance to review/sign (☐) log notes.

_____ I give permission for my child's pediatrician _____ to receive a copy of this IFSP.

_____I give permission for the Chair of my child's CPSE _____ to receive a copy of this IFSP.

_____ I have, to the best of my knowledge, given the most recent health insurance information to SCDSCSN.

_____Transition - Has (☐) Has Not (☐) been discussed.

Those services which are not in dispute will begin on the dates indicated on the IFSP.

[☐] I do not agree with the following aspects of the IFSP: _____

_____

[☐] I am requesting: _____

_____ _____ _____ _____

Parent/Guardian/Surrogate Signature Date EIOD Signature Date

The next IFSP meeting date is _____