BabyNet
South Carolina's Early Intervention System

___________________'s
Individualized Family Service Plan (IFSP)

Date of Referral: ________________ **Date of Plan:** ________________

SECTION 1: CHILD INFORMATION

Child's Name:____ Date of Birth:______________________
First Middle Last

Home Address:____

City:____ State: SC Zip Code:_________________________

Gender: M F Race: __________________ Name of School District and/or Head Start_______________________

Social Security #______________________________ Medicaid #: ______________________________________

Private Insurance Company Name and Policy #____

SECTION 2: GENERAL CONTACT INFORMATION

Parent/Guardian:____ Relationship to Child:______________________
First Last

Home Address:____

Directions to the home: ____

____

Phone: Home ____________________ Work:___________________ Other:_____________________

E-mail: ____

Primary Language/Mode of Communication:_____________________________ Interpreter Needed: Y N

Surrogate Parent Needed: Y N Date appointed: ______________________________

Other Contact information

Name:____ Relationship to Child:___________________________

Phone:____ Other phone: _______________________________

SECTION 3: SERVICE COORDINATION PROVIDER

BabyNet Service Coordinator (Intake) Name__________________________________ Phone____________________

BabyNet Service Coordinator (Ongoing) Name____

Service Coordination Provider Agency ______________________________________ Phone____________________

Other phone ________________________________ Email address____

Name (Last, First, MI):______________________________
DOB: ____
BabyTrac # ____
Medicaid #____
CARES #____

SECTION 4: IFSP TRACKING		
IFSP Meeting Date:		Type of IFSP: ☐ Initial ☐ Annual
Projected IFSP Team Meeting Dates:		
6-Month Review	Annual Evaluation	Transition
Date IFSP mailed:		
Family	Other IFSP Team Members	Primary Health Care Provider

SECTION 5A: FAMILY'S VIEW OF CHILD'S CURRENT HEALTH

Refer to BabyNet Birth and Early Health History in completing this section

Primary Healthcare Provider:

Does your child have a primary health care provider? ☐No ☐Yes

If not, there should be a linkage to a provider (reflected as a service coordination goal)

Primary Health Care Provider:____ **Phone:** ___________________

Address: ____ **Fax:** ____________________

General Health:

Is there anything about your child's current mental or physical health, including diagnosis(s) that the team should know in order to better plan to meet the priorities and concerns of you and your family? ☐No ☐Yes If yes, please describe:

Medication Routinely Taken	Reason for Medication

Does your child have any allergies? ☐No ☐Yes If yes, please list:

Allergy	Reaction

Name (Last, First, MI):_______________________________
DOB: ____
BabyTrac # ___________________________________
Medicaid #____________________________________
CARES #______________________________________

SECTION 5A: FAMILY'S VIEW OF CHILD'S CURRENT HEALTH, CONT.

Refer to BabyNet Birth and Early Health History in completing this section

Does your child use any specialized medical equipment, i.e., oxygen, pulse ox, g-tube, ventilator? ☐No ☐Yes
If yes, please list:

Hearing: Has your child's hearing been tested? ☐No ☐Yes
If yes, Date:_______________ Physician's Name:________________________________ *(If the appointment was within 6 months of referral to BabyNet, request the report and* ***DO NOT*** *complete Family Hearing and Vision Questionnaire)*
Results of hearing evaluation:

If no, proceed with the *Family Hearing and Hearing Questionnaire* and indicate the results: ☐Pass ☐Monitor ☐Refer

Referral to (Physician's name):____ Date of appointment:_______________

Comments by family or other IFSP team members:

Vision: Has your child's vision been tested? ☐No ☐Yes
If yes, Date:_______________ Physician's Name:________________________________ *(If the appointment was within 6 months of referral to BabyNet, request the report and* ***DO NOT*** *complete Family Hearing and Vision Questionnaire)*
Results of vision evaluation:

If no, proceed with the *Family Hearing and Vision Questionnaire* and indicate the results: ☐Pass ☐Monitor ☐Refer

Referral to (Physician's name):____ Date of appointment:_______________

Comments by family or other IFSP team members:

Nutrition: Are there any concerns about your child's eating, general nutrition, or growth? ☐No ☐ Yes
☐Special Formula (specify_________________) ☐Avoids certain textures ☐Food allergies
☐G-tube feedings (Bolus and/or continuous pump) ☐Will only eat certain foods ☐Special diet
☐Other, please list (ex., transitioning from G-tube to oral feeding):____
If yes to any conditions listed above please describe:

Comments by family or other IFSP team members:

Oral Health: Have your child's teeth or mouth been checked? ☐No ☐Yes
If yes, Date:_______________ Physician's Name:____
How long has/did your child use the following? Bottle __________ Mths/yrs Pacifier __________ Mths/yrs
Has your child been on any of the following medications for extended periods of time (3 months or more)?
☐Seizure Medications ☐Prescription Antibiotics
If yes to any conditions listed above please describe:

Comments by family or other IFSP team members:

Name (Last, First, MI):______________________________
DOB: ______________________________________
BabyTrac # _________________________________
Medicaid #_________________________________
CARES #___________________________________

SECTION 5B: HEALTH CARE PROVIDERS

Provider's Name______________________ Specialty______________________
Address______________________ Phone______________________

Provider's Name______________________ Specialty______________________
Address______________________ Phone______________________

Provider's Name______________________ Specialty______________________
Address______________________ Phone______________________

Provider's Name______________________ Specialty______________________
Address______________________ Phone______________________

Provider's Name______________________ Specialty______________________
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Provider's Name______________________ Specialty______________________
Address______________________ Phone______________________

Provider's Name______________________ Specialty______________________
Address______________________ Phone______________________

Provider's Name______________________ Specialty______________________
Address______________________ Phone______________________

Provider's Name______________________ Specialty______________________
Address______________________ Phone______________________

Name (Last, First, MI):______________________
DOB: ______________________
BabyTrac # ______________________
Medicaid #______________________
CARES #______________________

SECTION 6A: FAMILY VIEW OF CHILD'S PRESENT LEVEL OF FUNCTION

Social/Emotional: Are your child's **social skills** or **emotional development** of concern to you? ☐No ☐Yes

☐Smiles
☐Interest in Peers
☐Shows different emotion
☐Laughs
☐Responds to primary caregiver
☐Shows affection to familiar people
☐Expresses comfort/discomfort
☐Anxious when separated from caregiver

Other comments (if needed):

Communication: Are your child's **communication skills** of concern to you? ☐No ☐Yes

☐Tracks movement or sounds with eyes
☐Grunts
☐Babbles, no words
☐Smiles
☐Points
☐Indicates want/needs (looking, sounds, gestures, words)
☐Uses single words/phrases
☐Talks in sentences

Other comments (if needed):

Cognitive: Are your child's **thinking or problem-solving skills** of concern to you? ☐No ☐Yes

☐Follows moving objects with eyes
☐Puts small objects in/out of container
☐Recognizes familiar people
☐Looks at storybook, points to pictures often naming the item
☐Imitates actions and words of adults
☐Attends to activities of interest for short periods
☐Can match two similar objects

Other comments (if needed):

Self-help skills: Are your child's **self-help skills** of concern to you? ☐No ☐Yes

☐Formula/Breast fed only
☐Suck-swallow-breath coordination
☐Holds own bottle
☐Sucks/chews on crackers
☐Eats soft food only
☐Eats solid foods
☐Needs to be fed
☐Needs assistance with eating
☐Finger feeds
☐Feeds self with spoon
☐Feeds self with fork
☐Wears diapers
☐Needs to be dressed
☐Cooperates with dressing
☐Removes socks, shoes
☐Dresses independently
☐Toilet training in progress
☐Fully toilet trained

Other comments (if needed):

Motor skills: Is there anything about how your child **moves** that is a concern to you? ☐No ☐Yes

☐Head needs support
☐Holds head steady
☐Claps hands, plays patty cake
☐Rolls over
☐Sits with support
☐Can grasp objects with hand
☐Can grasp objects with fingers
☐Plays with toys, one hand
☐Plays with toys, both hands
☐Scoots
☐Crawls on hands and knees
☐Pulls to standing
☐Cruises holding on to things
☐Walks with assistance
☐Walks independently
☐Runs

Other comments (if needed):

Name (Last, First, MI):____________________
DOB: ____________________
BabyTrac # ____________________
Medicaid #____________________
CARES #____________________

SECTION 6B: ASSESSMENT OF CHILD'S PRESENT LEVEL OF FUNCTION	
Date of IFSP	Child's Name
Child's Chronological or Adjusted Age at time of CBA: _____ years _____ months	
List CBA Tool:	Name and agency of CBA Provider *please print*:
Overall strengths of child, successful strategies used in the assessment, and factors that may have affected assessment process	
CBA Results for Social –Emotional Domain	
Social-emotional skills child currently demonstrates:	
Skills newly learned/emerging:	
Skills not yet learned:	
Percentage of Delay or Area Goal Score in this domain:	
Date CBA conducted	Signature of CBA Provider

Name (Last, First, MI):______________________________
DOB: ____
BabyTrac # ______________________________________
Medicaid #_______________________________________
CARES #____

SECTION 6B: ASSESSMENT OF CHILD'S PRESENT LEVEL OF FUNCTION , CONT.	
CBA Results for Cognitive Domain	
Cognitive skills child currently demonstrates:	
Skills newly learned/emerging:	
Skills not yet learned:	
Percentage of Delay or Area Goal Score in this domain:	
CBA Results for Communication Domain	
Communication skills child currently demonstrates:	
Skills newly learned/emerging:	
Skills not yet learned:	
Percentage of Delay or Area Goal Score in this domain:	
Date CBA conducted	Signature of CBA Provider
SCFS/BN001	**Expires 30jun10**

Name (Last, First, MI):______________________________
DOB: ____
BabyTrac # _______________________________________
Medicaid #_______________________________________
CARES #____

SECTION 6B: ASSESSMENT OF CHILD'S PRESENT LEVEL OF FUNCTION , CONT.	
CBA Results for Self-Help/Adaptive Domain	
Self-help/adaptive skills child currently demonstrates:	
Skills newly learned/emerging:	
Skills not yet learned:	
Percentage of Delay or Area Goal Score in this domain:	
CBA Results for Motor Domain	
Gross motor skills child currently demonstrates:	Fine motor skills child currently demonstrates:
Gross motor skills newly learned/emerging:	Fine motor skills newly learned/emerging:
Gross motor skills not yet learned:	Fine motor skills not yet learned:
Percentage of Delay or Area Goal Score in this domain:	Percentage of Delay or Area Goal Score in this domain:
Date CBA conducted	Signature of CBA Provider

Name (Last, First, MI):________________________________
DOB: ____
BabyTrac # ____
Medicaid #____
CARES #____

SECTION 6C: OTHER TEAM MEMBERS' VIEW OF CHILD'S PRESENT LEVEL OF FUNCTION

To be completed at first IFSP Team's review of the Plan and each Annual IFSP Team Meeting

Social-emotional skills:

Cognitive skills:

Communication skills:

Self-help skills:

Motor skills:

Name (Last, First, MI):________________________________
DOB: ____
BabyTrac # ____
Medicaid #____
CARES #____

SECTION 7: FAMILY'S RESOURCES, PRIORITIES, AND CONCERNS (VOLUNTARY BY FAMILY)

Family declined family assessment of resources, priorities, and concerns Parent's initials: __________
Date Family Assessment completed:

I have questions about or want help for my child in the following areas (check all that apply):		Family's remarks regarding concerns identified about their child (including any not listed):
1	Moving around (crawling, scooting, rolling, walking)	
2	Ability to maintain positions for play	
3	Talking and listening	
4	Thinking, learning, playing with toys	
5	Feeding, eating, nutrition	
6	Having fun with other children; getting along	
7	Behaviors/appropriate interactions	
8	Expressing feelings	
9	Toileting; getting dressed; bedtime; other daily routines	
10	Helping my child calm down, quiet down	
11	Pain or discomfort	
12	Special health care needs	
Other		

I would like to share the following concerns and priorities for myself, other family members, or my child (check all that apply):		Family's remarks regarding identified priorities of the family (including any not listed):
1	Learning more about how to help my child grow and develop	
2	Finding or working with doctors or other specialists	
3	Learning how different services work or how they could work better for my family	
4	Planning for the future; what to expect	
5	Parenting skills	
6	People who can help me at home or care for my child so I/we can have a break; respite	
7	Child care	
8	Housing, clothing, jobs, food, or telephone	
9	Information on my child's special needs, and what it means	
10	Ideas for brothers, sisters, friends, extended family	
11	Money for extra costs of my child's special needs	
12	Linking with a parent network to meet other families, hare information (☐P2P ☐PTIC ☐CRS)	
Other		

Strengths, resources that our family has to meet our child's needs (**must** include statement of family's home and community routines and activities):

Name (Last, First, MI):______________________________
DOB: ____
BabyTrac # ____________________________________
Medicaid #_____________________________________
CARES #______________________________________

SECTION 8: ELIGIBILITY

INITIAL IFSP

Eligibility determination date: ________________________
Check one of the following:

☐ **Not eligible**

☐ **Established Risk:** Written documentation of a diagnosis listed in the BabyNet Manual.

☐ **Established Risk (not otherwise specified):** Written confirmation by DHEC pediatric consultant that child's condition or diagnosis meets eligibility criteria.

Diagnos(es):
____

____

☐ **Developmental delay** based on curriculum-based assessment (CBA) as documented below.

☐ **Developmental delay** as determined by informed clinical opinion and documented on ICO form per BabyNet manual requirements.

ANNUAL IFSP

IFSP Date: ______________________________________
Check one of the following:

☐ **No longer eligible**

☐ **Established risk:** condition previously documented continues.

☐ **Established risk (not otherwise specified)** condition previously documented continues.

☐ **Developmental delay** Curriculum-based assessment (CBA) reveals delay greater than 15% in any one domain. (ANNUAL evaluation of the IFSP only. Eligibility continues unless present level of performance in all domains has progressed to within normal limits [i.e., delays are equal to or less than 15% in all domains]).

IDEA/Part C (BabyNet) services are continued in order to (*check one*):

- ☐ Prevent regression (developmental losses)
- ☐ Continue developmental gains
- ☐ Help child reach developmental status of same-aged-peers

Curriculum-Based Assessment (CBA) Tool used:

Delay by Developmental Domain (percentage or Area Goal Score)

Social-Emotional	_________________	Self-Help	_________________
Cognition	_________________	Gross Motor	_________________
Communication	_________________	Fine Motor	_________________

Eligibility Determination Team Signatures, Participation

Name (printed)	Signature	Agency	On-site	Off-site

Name (Last, First, MI):_______________________________
DOB: ____
BabyTrac # ____________________________________
Medicaid #_____________________________________
CARES #______________________________________

SECTION 9: OTHER SERVICES

An ‘other service’ is a service necessary or desired to assure optimal child and/or family functioning; but not part of IDEA Part C or covered by BabyNet.
Other Services include, but are not limited to, housing, food stamps, WIC, TEFRA, clothing, respite, PCA, MR/RD Waiverservice,
including services in place at the time BabyNet eligibility established or added during implementation of the IFSP.

Resource/Service	Provider Name	Amount/Frequency/Intensity	Funding Source

Name (Last, First, MI):______________________________
DOB: ____
BabyTrac # _____________________________________
Medicaid #_____________________________________
CARES #_______________________________________

SECTION 10A: CHILD/FAMILY CENTERED GOAL

A goal is a statement of change the family would like to see happen for themselves and/or their child.

Goal #:	**Date of Goal:**	**Target Date:**

GOAL: What knowledge, skill or behavior would we like to learn or see learned by our child?

MEASURING PROGRESS:

What difference will this make for our child and/or family?

How will we know when the goal has been met? List specific skills from the CBA that are components of this goal

NATURAL SUPPORTS: Ideas, strategies, and people needed to achieve this goal within the child's everyday routines, activities, and places

ADAPTATIONS AND/OR MODIFICATIONS: Special accommodations/adaptations/equipment that can help make this happen (Assistive Technology).

SERVICES TO CONSIDER: What Part C and/or Other services are needed in order to achieve this goal in everyday routines, activities, and places?

WILL ALL SERVICES BE PROVIDED IN THE CHILD'S HOME & COMMUNITY ROUTINES & ACTIVITIES?

☐Yes ☐No: If no, check one: ☐Developmental/Medical Conditions ☐No Available Providers ☐Other:

JUSTIFICATION/EXPLANATION FOR PART C SERVICES OUTSIDE OF THE NATURAL ENVIRONMENT: What are the developmental, medical or other conditions that would require the service to be provided outside the family's home & community routines & activities?

Service	**Describe any interventions and/or efforts to provide services in everyday routines, activities, and places (RAP's) that were conducted and why these have been determined by the Team to be unsuccessful. The justification must include a plan for how services provided in any specialized setting will be generalized into the child's RAP's.**

Name (Last, First, MI):______________________________
DOB: ____
BabyTrac # __________________________________
Medicaid #__________________________________
CARES #____________________________________

SECTION 10A: CHILD/FAMILY CENTERED GOAL

A goal is a statement of change the family would like to see happen for themselves and/or their child.

Goal #:	**Date of Goal:**	**Target Date:**

GOAL: What knowledge, skill or behavior would we like to learn or see learned by our child?

MEASURING PROGRESS:
What difference will this make for our child and/or family?

How will we know when the goal has been met? List specific skills from the CBA that are components of this goal

NATURAL SUPPORTS: Ideas, strategies, and people needed to achieve this goal within the child's everyday routines, activities, and places

ADAPTATIONS AND/OR MODIFICATIONS: Special accommodations/adaptations/equipment that can help make this happen (Assistive Technology).

SERVICES TO CONSIDER: What Part C and/or Other services are needed in order to achieve this goal in everyday routines, activities, and places?

WILL ALL SERVICES BE PROVIDED IN THE CHILD'S HOME & COMMUNITY ROUTINES & ACTIVITIES?
☐Yes ☐No: If no, check one: ☐Developmental/Medical Conditions ☐No Available Providers ☐Other:

JUSTIFICATION/EXPLANATION FOR PART C SERVICES OUTSIDE OF THE NATURAL ENVIRONMENT: What are the developmental, medical or other conditions that would require the service to be provided outside the family's home & community routines & activities?

Service	Describe any interventions and/or efforts to provide services in everyday routines, activities, and places (RAP's) that were conducted and why these have been determined by the Team to be unsuccessful. The justification must include a plan for how services provided in any specialized setting will be generalized into the child's RAP's.

Name (Last, First, MI):______________________________
DOB: ____
BabyTrac # ____________________________________
Medicaid #_____________________________________
CARES #_______________________________________

SECTION 10A: CHILD/FAMILY CENTERED GOAL

A goal is a statement of change the family would like to see happen for themselves and/or their child.

Goal #:	**Date of Goal:**	**Target Date:**

GOAL: What knowledge, skill or behavior would we like to learn or see learned by our child?

MEASURING PROGRESS:

What difference will this make for our child and/or family?

How will we know when the goal has been met? List specific skills from the CBA that are components of this goal

NATURAL SUPPORTS: Ideas, strategies, and people needed to achieve this goal within the child's everyday routines, activities, and places

ADAPTATIONS AND/OR MODIFICATIONS: Special accommodations/adaptations/equipment that can help make this happen (Assistive Technology).

SERVICES TO CONSIDER: What Part C and/or Other services are needed in order to achieve this goal in everyday routines, activities, and places?

WILL ALL SERVICES BE PROVIDED IN THE CHILD'S HOME & COMMUNITY ROUTINES & ACTIVITIES?

☐Yes ☐No: If no, check one: ☐Developmental/Medical Conditions ☐No Available Providers ☐Other:

JUSTIFICATION/EXPLANATION FOR PART C SERVICES OUTSIDE OF THE NATURAL ENVIRONMENT: What are the developmental, medical or other conditions that would require the service to be provided outside the family's home & community routines & activities?

Service	**Describe any interventions and/or efforts to provide services in everyday routines, activities, and places (RAP's) that were conducted and why these have been determined by the Team to be unsuccessful. The justification must include a plan for how services provided in any specialized setting will be generalized into the child's RAP's.**

Name (Last, First, MI):______________________________
DOB: ____
BabyTrac # ___________________________________
Medicaid #____________________________________
CARES #_____________________________________

SECTION 10B: PERIODIC REVIEW OF GOAL

Goals may be reviewed, modified, and/or discontinued at any time but review period must not exceed 6 months.
See IFSP Change Review, IFSP Six-Month Review and Annual IFSP Goal Attainment Scale information on the following page.

Goal #: Date Reviewed: ☐ **Change Review** ☐ **6-month Review** ☐ **Annual Evaluation**

☐ 1-Situation changed, no longer needed	☐ 5-Goal attained or accomplished but not to team's satisfaction
☐ 2-Situation changed, is still needed	☐ 6- Goal mostly attained or accomplished to team's satisfaction
☐ 3-Intervention started, is still needed	☐ 7- Goal attained or accomplished to the team's satisfaction
☐ 4-Goal partially attained/accomplished but not to team's satisfaction	

Update to Natural Environments Justification Plan (developmental/medical conditions only):

Comments:

Goal #: Date Reviewed: ☐ **Change Review** ☐ **6-month Review** ☐ **Annual Evaluation**

☐ 1-Situation changed, no longer needed	☐ 5-Goal attained or accomplished but not to team's satisfaction
☐ 2-Situation changed, is still needed	☐ 6- Goal mostly attained or accomplished to team's satisfaction
☐ 3-Intervention started, is still needed	☐ 7- Goal attained or accomplished to the team's satisfaction
☐ 4-Goal partially attained/accomplished but not to team's satisfaction	

Update to Natural Environments Justification Plan (developmental/medical conditions only):

Comments:

Goal #: Date Reviewed: ☐ **Change Review** ☐ **6-month Review** ☐ **Annual Evaluation**

☐ 1-Situation changed, no longer needed	☐ 5-Goal attained or accomplished but not to team's satisfaction
☐ 2-Situation changed, is still needed	☐ 6- Goal mostly attained or accomplished to team's satisfaction
☐ 3-Intervention started, is still needed	☐ 7- Goal attained or accomplished to the team's satisfaction
☐ 4-Goal partially attained/accomplished but not to team's satisfaction	

Update to Natural Environments Justification Plan (developmental/medical conditions only):

Comments:

Name (Last, First, MI):______________________________
DOB: ______________________________________
BabyTrac # __________________________________
Medicaid #__________________________________
CARES #____________________________________

SECTION 11: SERVICE COORDINATION GOALS				
#	**Family-Identified Need (Family Assessment/as needs arise)**	**Action Taken (Teaming, Advocacy, Linkages)**	**Date Initiated**	**Date Completed**
	Linking to primary healthcare provider			
	Linking with a parent network to meet other families or share information (☐P2P ☐PTIC ☐CRS)			
	Transition from hospital or neonatal intensive care unit to home and into early intervention services to ensure no disruption of necessary services			
	Explore community program for our: ☐Child ☐Family			
	Child-related changes that may affect the IFSP service delivery (i.e., hospitalization, surgery, placement in a child care setting, addition of new equipment or technology, medication changes)			
	Child and family exiting BabyNet system prior to age 3			

Name (Last, First, MI):______________________________
DOB: ____
BabyTrac # _____________________________________
Medicaid #______________________________________
CARES #_______________________________________

SECTION 11: SERVICE COORDINATION GOALS

#	Family-Identified Need (Family Assessment/as needs arise)	Action Taken (Teaming, Advocacy, Linkages)	Date Initiated	Date Completed

Name (Last, First, MI):______________________________
DOB: ____
BabyTrac # ______________________________________
Medicaid #_______________________________________
CARES #____

SECTION 12: TRANSITION PLANNING			
Transition from Part C	**Target Date**	**Completion Date**	**Responsible Individual**
Discuss and educate parents on future placements, what "Transition" from BabyNet System means and what we can do to plan for this transition. Explore preschool education services as well as community program options.	Initial IFSP		
Discuss and educate parents about the differences between BN services and educationally related services under Part B of IDEA.	Age 2		
Discuss with family the need for current immunizations.	Age 2		
Determine need for new IFSP Goals to address transition-related knowledge, skills, and behaviors. Goal #_____ Goal #_____ Goal #_____ Goal # _____ Goal # _____	IFSP closest to age 2		
As part of the local school district's child find efforts, your child's name, birth date, your name, address and phone number will be sent by the BabyNet System Managers no later than 2 years to the ______________________ school district.	***No later than*** Age 2yrs		
With Parental permission make a referral to LEA and send information/records about child to LEA to ensure continuity of services, including evaluation and assessment of information and IFSPs no later than 2 years 6 months to the school district using the *Transition Referral* form with Section 2 completed.	***No later than*** Age 2 yrs, 6 months		
Send specified information/records to community programs, upon written consent, to facilitate service delivery or transition from BabyNet Early Intervention.	***No later than*** Age 2yrs , 6 months		
Transition Conference to be held no less than 90 days prior to the child's third birthday and (no more than 9 months prior).	***No later than*** Age 2yrs, 9 months		
Complete activities specified in Transition Plan section of *Transition Conference Form.*	Age 3		
BN Service Coordinator attends IEP at parent request.	***No Later than*** Age 3		

Name (Last, First, MI):_______________________________
DOB: ____
BabyTrac # ______________________________________
Medicaid #______________________________________
CARES #____

SECTION 13: BABYNET SERVICES

☐Add Service ☐Discontinue Service		☐Continue Service Date of IFSP Linked to Service:	
☐ Parent refuses/requests discontinuation of this service		Parent Initials:	Date:
BN Service CODE and Name:		IFSP Goals to Address:	
Provider:		Planned Start Date:	Planned End Date:
Actual Start Date:	Actual End Date:	Method CODE:	Fund CODE(s):
Setting CODE:	Visit Duration in Minutes:	Number of Visits: ______	☐Week ☐Month ☐Every Other Month ☐Quarterly
Travel Only: ☐No ☐Yes CODE:		If required, is service setting justified? ☐No ☐Yes	
If Child is Waiting for Service, Leave Start Date and Provider Blank and Enter Late Reason CODE:			

SECTION 13: BABYNET SERVICES

☐Add Service ☐Discontinue Service		☐Continue Service Date of IFSP Linked to Service:	
☐ Parent refuses/requests discontinuation of this service		Parent Initials:	Date:
BN Service CODE and Name:		IFSP Goals to Address:	
Provider:		Planned Start Date:	Planned End Date:
Actual Start Date:	Actual End Date:	Method CODE:	Fund CODE(s):
Setting CODE:	Visit Duration in Minutes:	Number of Visits: ______	☐Week ☐Month ☐Every Other Month ☐Quarterly
Travel Only: ☐No ☐Yes CODE:		If required, is service setting justified? ☐No ☐Yes	
If Child is Waiting for Service, Leave Start Date and Provider Blank and Enter Late Reason CODE:			

SECTION 13: BABYNET SERVICES

☐Add Service ☐Discontinue Service		☐Continue Service Date of IFSP Linked to Service:	
☐ Parent refuses/requests discontinuation of this service		Parent Initials:	Date:
BN Service CODE and Name:		IFSP Goals to Address:	
Provider:		Planned Start Date:	Planned End Date:
Actual Start Date:	Actual End Date:	Method CODE:	Fund CODE(s):
Setting CODE:	Visit Duration in Minutes:	Number of Visits: ______	☐Week ☐Month ☐Every Other Month ☐Quarterly
Travel Only: ☐No ☐Yes CODE:		If required, is service setting justified? ☐No ☐Yes	
If Child is Waiting for Service, Leave Start Date and Provider Blank and Enter Late Reason CODE:			

Name (Last, First, MI):________________________________
DOB: ____
BabyTrac # ____________________________________
Medicaid #_____________________________________
CARES #_______________________________________

SECTION 14: INITIAL AND ANNUAL IFSP CONSENT AND TEAM SIGNATURES

IFSP Meeting Notes:

Type of IFSP: ☐**Initial IFSP** ☐**Change Review** ☐**Six Month Review** ☐**Annual IFSP**

Accepting BabyNet Part C Services Recommended by the IFSP Team

- I have received a copy of my rights under Part C of IDEA (*Notice of Child and Family Rights in the BabyNet System*) and these have been explained to me along with this IFSP.
- My consent is voluntary and based on my understanding of the activities, which have been explained to me in my native language or mode of communication.
- I understand that my consent remains in effect until the next IFSP or IFSP Review and that I may revoke my consent in writing, at any time.
- I understand that I may decline a service or services without jeopardizing any other BabyNet service(s) my child or family receives.
- I understand that my IFSP will be shared among the service providers implementing this IFSP, others I may identify, and entities within the system per federal reporting requirements.

I have participated in the development of this plan, and give informed consent for BabyNet to carry out the activity/activities on this IFSP: ☐Yes ☐No

Signature of Parent(s):	Date:

IFSP Team Members
Method Codes: A = Attended, S = Speakerphone, E = Written Evaluation Only (not for ongoing service providers)

Signature/Name	**Role**	**Agency** (if applicable)	**Method Code**	**Date**
	BN Service Coordinator			

Name (Last, First, MI):____________________
DOB: ____________________
BabyTrac # ____________________
Medicaid #____________________
CARES #____________________

SECTION 15: MEDICAL AND THERAPY UPDATES	
Date	**Brief summary of appointment, including date and provider**
SCFS/BN001	**Expires 30jun10**

Name (Last, First, MI):______________________________
DOB: ____
BabyTrac # ____
Medicaid #____
CARES #____