Date: _____________

SERVICE SUMMARY PAGE

__________________________'s EARLY INTERVENTION SERVICES

The following Early Intervention Services were discussed with you and the other members of the EI Team and were determined to best meet your family's identified concerns and priorities. Evaluation/Assessment information, observations, and parental concerns were all considered in determining the services listed below:

BIRTH TO THREE SERVICES					
Services	**Start/End Dates**	**Location**	**Frequency/ Intensity**	**Cost**	**Funding Sources**
Service Coordination					

The above services were chosen to be part of your IFSP based on this information **AND** these reasons ____
____

Other services considered were ____________________________________ and were rejected based upon ____

- This plan reflects the outcomes that are important to my child and family.
- I give consent for the services described in the IFSP for my child and family.
- I understand that this plan will be shared with all team members listed on the following page so we can work in partnership on behalf of my family.
- You may refuse consent for particular procedures, evaluations or services while giving consent for others.
- You have the right to file a complaint regarding the proposed decision

I have received a copy of and understand the parent and child rights ______ (initial)

____
Parent/Guardian Signature(s) Date

____ ____
Service Coordinator LCHS B-3 Coordinator Authorization

Consent to bill private insurance: ☐ **Yes** ☐ **No** ☐ **No Insurance** **MA Coverage:** ☐ **Yes** ☐ **No**

Total Cost of IFSP: ____________________

If a service will not be provided in a natural environment, please attach a plan with steps to be taken to return the service location to a natural environment. Include what options were considered, assessments/evaluation, observations, as well as parent and child needs.

Date: ______________

IFSP Team Members

We have worked together to create this Individualized Family Service Plan and agree that this plan will guide our work.

IFSP TEAM MEMBERS	ADDRESS/PHONE
Parents:	
Service Coordinator:	
Team Member:	
Team Member:	
Team Member:	
Team Member:	
Team Member:	
Team Member:	

NEEDED MEDICAL AND OTHER SERVICES
(These are resources, supports or services that assist the family but are not funded by Birth to 3)
EXAMPLES MAY INCLUDE: Housing, Medical Assistance, Adaptive equipment, etc.

SUPPORTS NEEDED	WHO WILL HELP	STEPS TAKEN	FUNDING SRC

☐ IFSP Team discussion found that no medical or other services were identified at this time.

Comments: ____

____