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	n	Month 18 Month	24 Month 30 Month	☐36 Month ☐Amended		
(If this is an Amendment meeting, check amende	$d \text{ and}$ the IFSP period) \square Transition	Conference Transition I	Plan (check the transition cor	nf./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:	Fa	ther's/Guardian's Name:				
Child's Address:	Apt.	#Zip Code	Parents' Langu	age:		
(Street)	(Borough/City)					
Home Phone #: ()			Cell Phone #: ()			
Is child in foster care: () No () Yes If yes, pl	e e					
Foster Parent/Surrogate's Name:	Agency:	Caseworker's Name:				
Agency Address:		Phone #: ()				
			Fax #: ()			
Ethnicity: Hispanic Not Hispanic 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:					