Ohio Department of Health

Ohio's Individualized Family Service Plan

Help Me Grow A program of family supports and services for expectant parents, newborns, infants and toddlers and their families.

Ohio's Vision To assure that newborns, infants and toddlers have the best possible start in life.

Our vision for _____ and our family while in Help Me Grow is

Child's name	Date of birth
Child lives with (name)	(Relationship)

Interpreter needed? ☐ Yes ☐ No Surrogate parent ☐ Yes ☐ No

HMG Service Coordinator	Agency	
Phone	FAX	E-mail
Family Support Specialist	Phone	E-mail

Section I: **Family Information and Timelines**

Primary Care Giver Contact Information

☐ Parent(s) ☐ Guardian ☐ Custodial parent ☐ Foster parent (identify one)			Home telephone ( )
Address *street*	*city*	*state* *ZIP*	Cell telephone ( )
Native Language and / or communication method used Interpreter needed? ☐ Yes ☐ No		E-mail address	Work telephone ( )

☐ Parent ☐ Guardian ☐ Foster Parent (identify one)			Home telephone ( )
Address *street*	*city*	*state* *ZIP*	Cell telephone ( )
Native Language and / or communication method used Interpreter needed? ☐ Yes ☐ No		E-mail address	Work telephone ( )

Surrogate parent			Home telephone ( )
Address *street*	*city*	*state* *ZIP*	

Help Me Grow Timelines

Date of referral to HMG for ongoing services / /	Date of suspected delay (when applicable) / /	Date of developmental screening (not applicable if there is a diagnosed physical or mental condition) / /	Date determined eligible for ongoing HMG services / /
Initial IFSP IFSP reviews	Annual review IFSP reviews	Annual review IFSP reviews	
School District/ LEA	Initial Transition Plan date	Transition Planning Conference date	
Early Track ID number	BCMH number	Social Security number	Medicaid number
Healthy Start / CHIP number	Primary Insurance		

Section II: **Health and Medical Information**

Child's Medical Home: The doctor's office, health center or other place, you regularly take your child for check-ups, shots, or illness.

Name			Phone ( )
Mailing address			FAX ( )
City	State	ZIP	E-mail

Child's General Health (physical, emotional, behavioral) including: significant family, prenatal, medical or birth history or hospitalizations:

Dates of child's last well child check up? 2. 3. 4.			
/ /	/ /	/ /	/ /

Are immunizations:

☐ up to date ☐ late up to date ☐ not up to date ☐ not medically recommended

Are there any concerns about your child's dental health?

☐ Yes ☐ No *If Yes, specify*

Are there any concerns about your child's sleep patterns?

☐ Yes ☐ No *If Yes, specify*

Has your child been tested for lead?

☐ Yes ☐ No *If Yes, specify*

Does your child have allergies?

☐ Yes ☐ No *If Yes, specify*

Does your child take any medications?

☐ Yes ☐ No *If Yes, specify*

Does your child see any medical specialists?

☐ Yes ☐ No *If Yes, specify*

Does your child have a medical diagnosis?

☐ Yes ☐ No *If Yes, specify*

Does your child have a BCMH managing doctor?

☐ Yes ☐ No ☐ Pending If so, who is it?

Updated health information: e.g. ear infections, immunizations, hospitalizations.

Section III: **Present Level of My Child's Development**

This section should include all screening, evaluation and assessment information.

Child's name	Date of birth	Age chronological age-adjusted

Area of development	Screening/evaluation/assessment tool or method,* by whom and date	Results	Describe the child's strengths/needs in each area.
Cognitive/ problem solving			
Physical/Gross motor			
Physical/Fine motor			
Communication/Language			
Personal/Social and emotional			
Adaptive / self help			
Vision			
Hearing			
Nutrition			

*Method means Professional Observation or Parent Report.

Section IV: **Family Concerns and Priorities**

Please identify your concerns and your priorities related to enhancing the development of your child. This will assist us in developing a child or family outcome with you.

Child's name	Date of birth

Caregiver(s) have questions about, or want help for my child in the following areas:

- ☐ Assistive technology or other equipment/supplies
- ☐ Behavior (helping my child calm down, be comfortable, getting along with others, biting, expresses feelings)
- ☐ Eating and drinking (sucking, breastfeeding, taking a bottle, using a spoon)
- ☐ Helping my child learn to read
- ☐ Information about diagnosis or disability
- ☐ Information on whether my child's condition is hereditary
- ☐ Language (cooing, babbling, smiling, talking and listening)
- ☐ Learning new things
- ☐ Moving around (holding head up, rolling, sitting, crawling, standing, walking)
- ☐ Pain or discomfort
- ☐ Safety in our home and other places
- ☐ Self Help (diapering, toileting, dressing, sleeping, other daily routines)
- ☐ Special health care needs
- ☐ Other
- ☐ Vision and Hearing (responding to what they hear and see)

Caregivers want information about or help with:

- ☐ Budgeting
- ☐ Child care
- ☐ Discussing emotional issues for myself and child(ren)
- ☐ Education for myself
- ☐ Family conflict
- ☐ Finding or working with doctors or other specialists
- ☐ Help with insurance
- ☐ Housing, clothing, jobs, food, telephone
- ☐ Ideas for siblings, friends, extended family members
- ☐ Improving my parenting skills
- ☐ Learning how different services work and how they could work better for my family
- ☐ Legal
- ☐ Linking with other parents
- ☐ Managing anger
- ☐ Meeting my child's special health care needs
- ☐ Money for extra costs relating to my child's special needs
- ☐ Obtaining respite care
- ☐ Planning for the future; what to expect
- ☐ Recreation
- ☐ Safety in our home (smoke alarms, first aid supplies)
- ☐ Spending time with family and friends, social interaction skills
- ☐ Transportation services for my child or family

Comments/Priorities:

Section V: **Everyday Routines, Activities and Places (ERAP) Demographics and Timelines**

It is helpful for us to know where your child regularly spends time, because young children learn best through their routines and in activities which interest them.

A. What is a typical day like for your child and family?

B. What does your child and family like to do together?

C. What does your child and family find challenging or difficult to do? e.g. people, activities.

Section VI: **Outcome** _____ Number_____

Child's name	Date of birth	Date outcome written

What do we want to happen in the next 6 months? (refer to Section IV: **Family Concerns and Priorities**)

What's happening now? (include a pre-literacy and language skills as developmentally appropriate)

What supports and resources do I/we have available to achieve this outcome?

Who will help us and what strategy will they use so we can achieve our outcome? These strategies are to occur during our child/family's daily activities and routines. (refer to Section V: Everyday Routines, Activities and Places – ERAP)

After reviewing our outcome, my family and IFSP team, have decided:

Date of IFSP review

☐ My child and/or family met this outcome.

☐ We have partially met this outcome. Why?

☐ The outcome was not met. Why?

Section VIII: **Transition at Age Three Outcome**

For: ☐ Preparation for Transition Planning Conference
☐ Transition Planning Conference at least 90 days prior to 3rd birthday

Child's name	Date of birth

A. What do we want to happen before _____ turns three and leaves Help Me Grow?
(e.g. preparing the child and family for change and identifying possible options)

B. Who will help us and what strategy will they use so we can achieve our goal to ensure a smooth transition?

C. After reviewing our transition goal, my family and IFSP team (and the LEA, if applicable) have decided that at age three:

☐ My child and/or family met this outcome.
☐ We have partially met this outcome. Why?
☐ The outcome was not met. Why?

Exit reason
Exit destination

Section IX: **Transition Documentation Checklist**

Child's name	Date of birth

Italics = Child may qualify for Part B Services

Between 6–9 months prior to child's third birthday begin preparing for the Transition Planning Conference.	**Projected date**	**Actual date**	**Service coordinator's initials**
1. Discuss the transition process and develop outcome(s) and activities/strategies on the Individual Family Service Plan (IFSP).			
2. Review child's progress and identify any concerns.			
3. Identify possible program options (public preschool, Head Start, preschool special education, childcare, other)			
4. Identify participants for the Transition Planning Conference. *If the child is suspected of having a disability at age 3, the LEA representative, with parent permission, must be invited to attend the transition planning conference.*			
5. Obtain informed written parental consent to invite identified participants.			
6. Obtain written parental consent for the release of records (specify what records are to be released and to whom).			
7. Determine mutually agreed upon time and date for Transition Planning Conference (90 days or up to 9 months before the child's third birthday).			
8. Send each identified individual/agency written notification of the Transition Planning Conference including the date, time and location.			

At least 90 days prior to the child's third birthday, hold the transition planning conference with invited participants.	**Projected date**	**Actual date**	**Service coordinator's initials**
1. Discuss transition process, review and update IFSP to include a family-driven outcome and a sequence of activities that will ensure a smooth transition by age three.			
2. *The LEA /school district representative will:* *a. Inform family of the due process and procedural safeguards.*			
b. Review child's records.			
c. Decide with family and other team members if there is a suspected disability.			
3. *If a disability is suspected, complete a Referral for Evaluation PR-04.*			
4. *Obtain written parental permission for a multi – factored evaluation (MFE) using the Parent Consent for Evaluation form PR-05.*			
5. If a disability is not suspected the team explores other options.			

Section X: **IFSP Signatures and Consents**

Child's name	Date of birth

Please check all that apply:

- ☐ I participated fully in the development of this plan and give my consent to implement the IFSP.
- ☐ I have been given and understand my parents rights under Help Me Grow.
- ☐ I understand my child is eligible for additional rights under Part C of IDEA.
- ☐ I understand I can ask the team and anyone else to meet to make changes to this IFSP at any time.
- ☐ I consent to provide a copy of the following sections of my IFSP to _____.
  - ☐ All sections ☐ Only sections _____
- ☐ I consent to provide a copy of this IFSP to my IFSP team.

Parent/Guardian/Surrogate Parent signature	Date

IFSP Team Member's Approval of Plan:
We agree that the goals/outcomes selected reflect the family's priorities and concerns and the strategies selected support those goals. We agree to carry out the plan in a manner that supports the family's ability to help their child participate in and learn from their everyday routines and activities whenever possible.

Signature (or printed name if not in attendance)	Title/Role/Agency	Method of Participation*	Date
	Service Coordinator	Present	

* Method includes present (P), written (W), conference call (C)