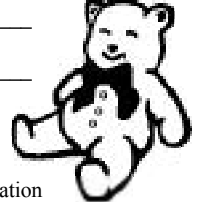


MARYLAND INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP)

Referral Date: _____

Meeting Date: _____

IFSP Type: Interim
 Initial
 Annual Evaluation



Child and Family Information

Child: _____

Birthdate: _____

ID Number: _____

MA Number: _____

Address: _____

Phone: () _____

Name: _____

Phone: () _____

Parent(s)/Guardian/Surrogate

() _____

Address: _____

Service Coordinator Information

Name: _____

Agency: _____

Address: _____

Phone: () _____

() _____

Part I: IFSP Signatures

I (We) have had the opportunity to participate in the development of this IFSP and have been provided with reasonable notice of the IFSP meeting. I (We) have been informed of my (our) rights under this program, through receipt of the *Dreams and Challenges* handbook and the *Parents' Rights in the Early Intervention System* brochure. I (We) understand the plan, and parental rights, and I (we) give permission to implement this plan.

 Parents/Guardian/Surrogate Date

Each agency or person who has a direct role in the provision of early intervention services is responsible for making a good faith effort to assist each eligible child and family to achieve the outcomes on the child's IFSP.

 Interim Service Coordinator Date

 Evaluator/Assessor Participation (check one):
 Signature of Evaluator/Assessor in attendance
 Signature of Authorized Representative in attendance
 Name of telephone contact
 Written report

 Service Coordinator Date

 Lead Agency Representative Date

 Other Participant Agency/Title Date

 Interpreter (if needed) Date

 Other Participant Agency/Title Date

 Other Participant Agency/Title Date
 8/2003

 Other Participant Agency/Title Date