

INDIVIDUALIZED FAMILY SERVICE PLAN

Date: ___/___/___

PART III: BACKGROUND INFORMATION AND DESCRIPTION OF CHILD'S PRESENT LEVELS OF DEVELOPMENT (be sure to indicate which are areas of strength and need for the child)

PERTINENT BACKGROUND INFORMATION: _____

ASSESSMENT INCLUDED:

- Parent Report
- Observation
- Assessment Instrument(s):
- HOPE
- HELP
- Other: _____

PHYSICAL DEVELOPMENT:

HEALTH (identify only major issues - see attached summary): _____

CHILD HAS MEDICALLY IDENTIFIED VISION LOSS: Yes No

VISION (documentation required): Tools used: First Look Other: _____

Did the child pass the screening? Yes No If no, outcome/intervention to be provided must be written.

CHILD HAS MEDICALLY IDENTIFIED HEARING LOSS: Yes No

HEARING (documentation required): Tools used: HEAR Kit Other: _____

Did the child pass the screening? Yes No If no, outcome/intervention to be provided must be written.

MOTOR DEVELOPMENT:	CHRONOLOGICAL AGE _____	DEVELOPMENT LEVEL
Gross Motor: _____		
Fine Motor: _____		
COGNITIVE DEVELOPMENT (how child responds to/interacts with the environment, solves problems):		

COMMUNICATION DEVELOPMENT (Language and Speech):		
Receptive (understanding): _____		

Expressive (making sounds, talking, gestures, signs): _____		

SOCIAL/EMOTIONAL DEVELOPMENT (how child relates to others):		

ADAPTIVE/SELF-HELP DEVELOPMENT (sleeping, eating, dressing, toileting):		

CHILD'S NAME _____

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