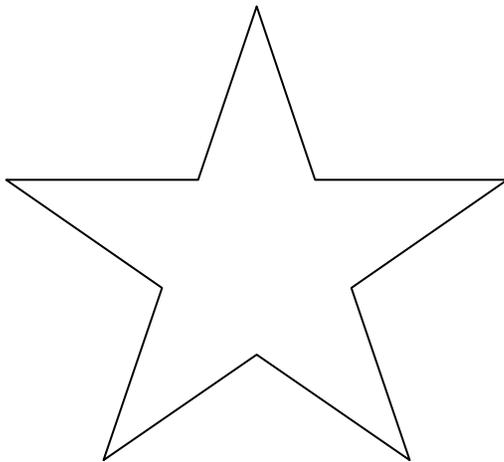




DELAWARE MULTIDISCIPLINARY ASSESSMENT/  
INDIVIDUALIZED FAMILY SERVICE PLAN  
FOR THE FAMILY OF



\_\_\_\_\_

Date of Birth: \_\_\_\_\_

ISIS Number: \_\_\_\_\_

Plan Date: \_\_\_\_\_

Review Date: \_\_\_\_\_

MDA Only

**Section 1** Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Plan Date: \_\_\_\_\_

**DELAWARE MDA/IFSP**

Interim (See section 11) Date: \_\_\_\_\_  Annual Date: \_\_\_\_\_  Review Date: \_\_\_\_\_

Sex: \_\_\_\_\_ MCI/ISIS# Error! Reference source not found. Eligibility (Y N) date: \_\_\_\_\_ Primary Language: \_\_\_\_\_

Resident School District: \_\_\_\_\_ Eligibility Determination Method:  
 Dev. Delay  Established Condition  Clinical Judgment

	Parent(s) <input type="checkbox"/> Child Resides with	Guardian/Family Member/Other <input type="checkbox"/> Child Resides with	Foster Care Agency / Worker Name & Address <input type="checkbox"/> Child Resides with
Name:			
Street Address:			
City:			
Zip:			
Home Telephone:			
Work Telephone:			
Cell Telephone:			
Email Address:			

Doctor/Medical Home: \_\_\_\_\_ Dr. Telephone # \_\_\_\_\_ Fax #: \_\_\_\_\_

Insurance Carrier/Insurance #/ Insured: \_\_\_\_\_

Insurance Carrier/Insurance #/ Insured: \_\_\_\_\_

Child's present concerns and /or diagnosis: \_\_\_\_\_

Service Coordinator: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Email: \_\_\_\_\_

**Section 2** Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Plan Date: \_\_\_\_\_

**IDENTIFYING NATURAL LEARNING ENVIRONMENTS**

**FAMILY AND CHILD PREFERENCES, STRENGTHS AND RESOURCES**

What is soothing to your child? What is your child's favorite activity (toy, game, playtime)?

What is your child's/family's daily routine? Where/with whom does your child spend time? How often/how much time?

What does your child do well? On most days, what goes well and what is difficult?

Who is part of your family? Is extended family nearby and are they supportive?

How do you and your family get to places you need to go? Do you have a child safety seat for a car?

How do you presently meet your child's needs for opportunities to interact with other children? What people and agencies do you find helpful?

Additional Information:

FAMILY AND CHILD CONCERNS AND PRIORITIES

**CONCERNS AND PRIORITIES:**

Why are you interested in receiving help for your child?

When were you first concerned?

How do your child's special needs affect the family? Describe activities/routines that your family is not currently involved in because of your child's special needs, but that you are interested in doing now or in the near future?

What is most important to you now and how can we help?

**I WANT TO KNOW MORE ABOUT:**

- Meeting with other families to share information about a child like mine
- Planning for the future
- People who can help me at home or care for my child so I/we can have a break
- Resources for housing, clothing, jobs, food, telephone, child care
- Getting and paying for equipment, supplies, and assistive technology devices
- Locating a doctor or dentist
- Age appropriate developmental skills
- Other: \_\_\_\_\_

**I WOULD LIKE TIPS FOR:**

- Effective discipline for my young child
- Using time-outs
- Toilet training
- Helping my child stay dry
- How to stop bed-wetting
- Handling hair pulling
- Stopping my child from biting others
- Stopping temper tantrums
- Helping my child become independent
- Parenting a "hyperactive" child
- How to help my child feel special
- Helping my fearful child
- Helping my child make changes
- How to stop sleeping problems
- How to prepare my child for a new baby
- Helping my children adjust to a new baby
- What to do when my children fight
- Teaching my children to share
- Helping step-brothers and step-sisters live together
- Parenting the brother/sisters of a child with a medical or handicapping condition.

**Section 4** Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Plan Date: \_\_\_\_\_

**DEVELOPMENTAL STRENGTHS AND CONCERNS FOR THE CHILD**

**1. COGNITIVE:**

These skills are the manner in which your child thinks and solves problems. At a young age, these skills include finding objects that have been removed from their view, recognizing themselves as the causes of events, matching simple shapes/colors, responding to one and one more, remembering details of a simple story and remembering where things belong in the house.

<b>Present Level of Functioning:</b>	<b>Strengths / Resources</b>	<b>Concerns / Needs / Priorities</b>
<b><u>Family Input:</u></b>		
<b><u>Assessment Results</u></b> Date:  Assessment:  Age at Evaluation:  Corrected Age:  <u>Circle One:</u> Developmental Delay    DD Partial Delay            PD No Delay                    ND Age Appropriate        AA		
<b><u>Clinical Impressions and Recommendations</u></b> (Including behaviors, history, what impacted assessment, distractions, special adaptations.):     <b><u>Assessor:</u></b>		

**Section 4** Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Plan Date: \_\_\_\_\_

**DEVELOPMENTAL STRENGTHS AND CONCERNS FOR THE CHILD**

**2. ADAPTIVE:**

These self help skills are activities such as eating and dressing; the ability of children to focus their attention, and demonstrate their growing personal responsibility. This includes eating, toileting, dressing and attention skills. Is your child toilet trained? Does he/she require assistance in removing/putting on a jacket? How long can your child maintain attention to an activity? What activities does he/she tend to focus on the most?

<b>Present Level of Functioning:</b>	<b>Strengths / Resources</b>	<b>Concerns / Needs / Priorities</b>
<b><u>Family Input:</u></b>		
<b><u>Assessment Results</u></b> Date:  Assessment:  Age at Evaluation:  Corrected Age:  <u>Circle One:</u> Developmental Delay    DD Partial Delay            PD No Delay                    ND Age Appropriate        AA		
<b><u>Clinical Impressions and Recommendations</u></b> (Including behaviors, history, what impacted assessment, distractions, special adaptations.):     <b>Assessor:</b>		

**Section 4** Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Plan Date: \_\_\_\_\_

**DEVELOPMENTAL STRENGTHS AND CONCERNS FOR THE CHILD**

**3. SOCIAL / EMOTIONAL:**

Social/Emotional skills are the ways the child interacts with adults and peers, how they express their feelings. This includes familiar adults, other children and strangers. Does your child follow routine directions? Does he/she share toys with other children? Does he/she prefer to play alone or with others?

<b>Present Level of Functioning:</b>	<b>Strengths / Resources</b>	<b>Concerns / Needs / Priorities</b>
<b><u>Family Input:</u></b>		
<b><u>Assessment Results</u></b> Date:  Assessment:  Age at Evaluation:  Corrected Age:  <u>Circle One:</u> Developmental Delay    DD Partial Delay            PD No Delay                    ND Age Appropriate        AA		
<b><u>Clinical Impressions and Recommendations</u></b> (Including behaviors, history, what impacted assessment, distractions, special adaptations.):          <b>Assessor:</b>		





**Section 5** Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Plan Date: \_\_\_\_\_

**HEALTH ASSESSMENT**

<b>Present Levels of Functioning</b>	<b>Strengths / Resources</b>	<b>Concerns / Needs / Priorities</b>
Primary Care Physician:		
Vision:		
Hearing: (newborn screen, # ear infections, tx?)		
Nutrition: (eating patterns, fluid intake, bottle/breast)		
Growth and Development: (birth weight, length, dev milestones)		
Significant Medical Findings: (diagnoses)		
Health History: (birth history, immunizations, accidents, illnesses, hospitalizations, last physical)		
Other Specialty Medical Follow up:		





**Section 8** Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Plan Date: \_\_\_\_\_

**NATURAL ENVIRONMENTS (NE):** Early Intervention services must be provided in NE (settings that are natural/typical for the child's age peers who have no disabilities) to the maximum extent appropriate, and can only be provided in settings other than NE when outcomes cannot be achieved satisfactorily in NE. The Individuals with Disabilities Education Improvement Act of 2004 (IDEA) requires justification to support the IFSP team decision that outcome/strategies cannot be achieved satisfactorily in NE.

Outcome #	1) Why outcomes/strategies cannot be achieved in the NE?	2) Plan/timeline to move service(s) into the NE.

All services provided in Natural Environments



Section 10: Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ School District: \_\_\_\_\_

**TRANSITION PLAN**

**PLAN FOR TRANSITION FROM THE BIRTH TO THREE SYSTEM  
TO PRESCHOOL SPECIAL EDUCATION OR OTHER APPROPRIATE SERVICES**



Purpose for this plan: \_\_\_\_\_ Conference Date: \_\_\_\_\_

Anticipated Transition Date: \_\_\_\_\_ Conference notes: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Use Triplicate Form

Next Steps	Person Responsible	Date to be Completed	Completed
			<input type="checkbox"/>
Fax Transition Plan to Service Providers.			<input type="checkbox"/>
<input type="checkbox"/> Family requests that CDW Service Coordinator be invited to IEP meeting.			<input type="checkbox"/>

**PERSONS INVOLVED IN TRANSITION PLANNING**

(Persons required to attend are family member(s) and the service coordinator. If the child has been referred to a school district for determination of eligibility for pre-school special education, then a representative of the child's school district must also attend.) Place a check in the small box to indicate attendance at the conference.

Name	Title	Phone	<input type="checkbox"/>	Name	Title	Phone	<input type="checkbox"/>

Parent: \_\_\_\_\_ Date: \_\_\_\_\_ Service Coordinator: \_\_\_\_\_ Date: \_\_\_\_\_ School District Representative: \_\_\_\_\_ Date: \_\_\_\_\_

**Section 11** Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Plan Date: \_\_\_\_\_

**ADDITIONAL COMMENTS**

This section is provided for any additional comments that the parents, service coordinator and/or other team members feel would be helpful. Each comment should be **dated** and **signed**.

Interim IFSP due to:

Unable to complete MDA due to child's condition

Eligible child has immediate service needs prior to the MDA

**Explanation:**

**Anticipated MDA date:** \_\_\_\_\_

**Additional Comments:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Mailed IFSP to Family: (Date: \_\_\_\_\_ )

Mailed IFSP to Family: (Date: \_\_\_\_\_ )

**Section 12** Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Plan Date: \_\_\_\_\_

**SIGNATURE PAGE**

I had the opportunity to participate in the development of this IFSP. I understand the plan, and I give permission to **Child Development Watch** to carry out the plan with me.

- I have received and read a copy of Family's Rights.
- I have had the opportunity to receive and review the Division of Public Health's Notice of Privacy Practices.
- IFSP Meeting Notice sent or Waiver signed

\_\_\_\_\_  
**Signature of Parent(s) / Legal Guardian(s)/ Educational Surrogate**

\_\_\_\_\_  
**Plan Date**

The following individuals participated in the development of the IFSP. Each person understands and agrees to carry out the plan as it applies to their role in the provision of services. Please include name, role and relationship to the child.

**Initial Plan Date:** \_\_\_\_\_

**Signature** \_\_\_\_\_ **Role / Relationship** \_\_\_\_\_

**Signature** \_\_\_\_\_ **Role / Relationship** \_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

I had the opportunity to participate in the development of this IFSP. I understand the plan, and I give permission to **Child Development Watch** to carry out the plan with me.

- I have received and read a copy of Family's Rights.
- I have had the opportunity to receive and review the Division of Public Health's Notice of Privacy Practices.
- IFSP Meeting Notice sent or Waiver signed

**Plan Date:** \_\_\_\_\_

\_\_\_\_\_  
**Signature** \_\_\_\_\_ **Role / Relationship** \_\_\_\_\_

\_\_\_\_\_  
**Signature** \_\_\_\_\_ **Role / Relationship** \_\_\_\_\_

\_\_\_\_\_

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