Confirmation of Individualized Family Service Plan (IFSP) Schedule  

Date: __________________

Dear: __________________________________________________

I would like to confirm the IFSP team meeting/review schedule previously discussed for your child. The IFSP team meeting/review has been scheduled at the convenience of your family and can be rescheduled if needed. The IFSP meeting/review has been scheduled for:

__ __________________ __________________ __________________
Date    Time    Place

The type of IFSP meeting/review that this will be is:

☐ initial   ☐ annual   ☐ 6-month review   ☐ other ________________________________

As we have talked about, the purpose of the IFSP team meeting/review is to discuss information related to your child's development and to develop a family plan which includes outcomes, strategies, services and supports determined appropriate for your child and family by the team. An initial IFSP must be completed within 45 calendar days from the time your child was referred to Part C unless you extend this timeline to meet your family's needs. Thereafter, IFSP's must be reviewed every six months and an annual meeting/review must be held to evaluate the IFSP and revise as necessary.

Individuals who will provide information to develop the IFSP are listed below. They may not actually be present at the meeting/review, but they will provide written or oral information. All of this information will be shared with you at the meeting/review. You may invite anyone you wish to participate in the meeting/review.

<table>
<thead>
<tr>
<th>Names (Individual or Providing Agency)</th>
<th>Discipline</th>
</tr>
</thead>
</table>

Please call me/us if you have any questions about the above information or schedule.

Sincerely,

________________________________________________________________________________________

Name(s)/Title(s)

cc: IFSP Team Members (listed above)

Note: Parents are to receive a copy of this form.

☐ Mailed   ☐ Hand Delivered

DMH 888E 1048 R7/10