Child Name: DOB: Meeting Date: 02/26/2014

IFSP Meeting Details

Meeting Type: ☐ Initial ☐ Periodic ☑ Annual

45-day timeline met for Initial IFSP Meeting? ☐ Yes ☐ No	
Reason if not met: ☐ Family ☐ Agency ☐ Other	Describe other reason:

Meeting Participants (includes all Periodic Review Methods)			
Name	**Role**	**Agency**	**Method of Participation**
	Service Coordinator Evaluator Service Provider	Keystone AEA	Meeting
	Parent		Meeting
	Evaluator Service Provider	Keystone AEA	Written Record/Report
	Evaluator Service Provider	Keystone AEA	Written Record/Report

Overall Primary Setting (IT Code) (select one only for each IFSP)

- ☐ IT1 Program designed for children with developmental delay/disability
- ☐ IT2 Program designed for typically developing children
- ☑ IT3 Home
- ☐ IT4 Hospital (Inpatient)
- ☐ IT5 Residential Facility
- ☐ IT6 Service Provider Location
- ☐ IT7 Other Setting

NOTES:

Prior Written Notice by a Public Agency*/Service Provider

To: _____ Child's Name: _____
Parent/Guardian Name

Date: 02/26/2014 Child's Date of Birth: _____

As the parents of a child ☑ eligible/ ☐ not eligible/ ☐ eligibility not determined for early intervention services, you have protections under the procedural safeguards of the Individuals with Disabilities Education Act. These rights are detailed in the Early ACCESS Procedural Safeguards Manual for Parents produced by the Iowa Department of Education. The manual contains information of whom to contact to obtain assistance in understanding your rights. The complaint process is also found in the manual, as well as a model form with the address provided. A copy of this manual was provided on 02/26/2014. You may ask questions about your parental rights and obtain additional copies of the manual by contacting your Service Coordinator.

You have a right to receive written notice under the following situations: 1) A public agency or service provider **proposes** to initiate or change the identification, screening, evaluation or placement of your child or the provision of appropriate early intervention services to your child and family; or 2) a public agency or service provider **refuses** to initiate or change the identification, screening, evaluation or placement of your child or the provision of appropriate early intervention services to your child and family that your have requested.

1. A description of the action:
   Service: PT Physical Therapy Provider:
   Method: Individual Sessions Occur: 2 time(s) per Month for 45 minutes
   This service began or will begin: 06/25/2012 The service ended or will end on:
   If this service is ending, the reason is:

   Service: SC Provider:
   Method: Individual Sessions Occur: 1 six month period for 60 minutes
   This service began or will begin: 05/17/2012 The service ended or will end on:
   If this service is ending, the reason is:

   Service: SI Developmental Services Provider:
   Method: Individual Sessions Occur: 2 time(s) per Month for 45 minutes
   This service began or will begin: 06/06/2012 The service ended or will end on:
   If this service is ending, the reason is:

   Service: Speech and Language Services Provider:
   Method: Individual Sessions Occur: 2 time(s) per month for 30 minutes
   This service began or will begin: 02/26/2014 The service ended or will end on:
   If this service is ending the reason is:

2. An explanation of why the public agency or service provider proposes or refuses to take the action:
   Speech and Language services will be added to [redacted]'s plan since she is showing a delay in that area. All other services will remain the same.

* Public Agency means the Iowa Department of Education and any other political subdivision of the state that is responsible for providing early intervention services to children eligible under IDEA and Early ACCESS rules. The Iowa Department of Education is responsible for the Early ACCESS complaint/due process system.

Child Name: [redacted] DOB: [redacted] Current Date: 03/14/2014

Individualized Family Service Plan
Meeting Notice

Parent/Guardian Name(s): [redacted]	
Address: [redacted] City, State, Zip	Phone: [redacted] H W C
	Email:

Meeting Date: 02/26/2014 Meeting Time: 11:00 AM Location: Your Home

Meeting Purpose: ☐ Interim IFSP ☐ Initial IFSP Meeting ☐ Periodic Review ☑ Annual Review
☐ Transition Planning

Discussion will relate to:
- Parent Rights
- Outcome Progress and planning
- Speech services addition
- Service planning

The following people have been invited to attend this meeting. As parents/guardians, you may invite others to the meeting if you choose.

Name	Role/Discipline
[redacted]	Service Coordinator
[redacted]	Parent
[redacted]	Physical Therapist
[redacted]	Speech and Language Therapist

If you have any questions, please contact:

Service Coordinator: [redacted]	Phone: [redacted]
Email: [redacted]	