ARKANSAS INFANT & TODDLER PROGRAM
INDIVIDUAL FAMILY SERVICE PLAN

Date and Type of IFSP Meeting
Initial _____
Update _____
Annual _____

Background and Family Information							
Child's Name	DOB	Age	DDS ID *	SS#	Medicaid *	CMS #	Phone #

Parent's Name	Street Address	City	County	Zip Code

Referral Date	Referral Source	Reason For Referral

Family Resources

Current Services & Financial Resources		Family Supports		Social Supports	
Service	Contact #	Person	Phone #	Person	Phone #

Priorities: What is their priority for their child (Child Specific)	Concerns: What does the family need to help them help their child? (Family Specific)

Directions to the family's home	Primary Language Spoken in the home

Initial Service Coordinator:	Ongoing Service Coordinator: