QUARTERLY IFSP REVIEW COVER SHEET

State Form 51840 (R2 / 1-12)

Use the back of this form for notes, if needed.

Name of child			Date of birth *(month, day, year)*
Date of meeting *(month, day, year)*	Time in	Time out	Quarter ☐ First ☐ Second ☐ Third
Name of service coordinator			County

Policy: In an effort to ensure that all early intervention records maintained at the SPOE office are complete, Service Coordinators will submit the following information, at one time, for an IFSP Review. This checklist must be attached in order for the modified IFSP to be data entered.

☐ Cover sheet	☐ Provider progress reports	☐ Additional outcome pages (if needed)
☐ Ten (10) day prior written notice	☐ ED Team Review (if needed)	☐ Family information update form (if needed)
☐ IFSP outcome review page	☐ Meeting minutes / request for authorization	☐ Change page (*See* *Note)

*Note: If a change in service is made as a result of this meeting, the "Change Page" may be submitted to the SPOE once all necessary signatures have been obtained. Please do not submit a Change Page without the Physician's signature page if adding or increasing a service.

The list below includes talking points that should be used as a conversation starter.

	YES	NO
1. Have you received your Explanation of Benefits (EOB)? *If No, explain:*	☐	☐
2. Do you understand your cost participation? *If No, what questions do you have?*	☐	☐
3. Are there any changes in your information? Ex: Income, Family Members, Address, Insurance *If Yes, explain the changes:*	☐	☐
4. Have you received face to face sheets from providers for services they have performed? *If No, Next Steps:*	☐	☐
5. Has your provider discussed with you about receiving a progress report from them? *If No, Next Steps:*	☐	☐
6. Do you feel comfortable addressing your concerns with the providers? *If No, Next Steps:*	☐	☐
7. Are you satisfied with the IFSP outcomes and services provided? *If No, Next Steps:*	☐	☐
8. Have your providers discussed any changes in services or the IFSP outcomes? *Next Steps:*	☐	☐
9. Are there any transition activities to be initiated over the next three (3) months? *Next Steps:*	☐	☐

Disclaimer – Any incomplete date boxes will be filled in by Service Coordinator after signature date.

Service Coordinator Signature	Date *(month, day, year)*	Telephone ( )
Parent Signature	Date *(month, day, year)*	Telephone ( )

Next visit scheduled? ☐ Yes ☐ No	If yes, date *(month, day, year)*