### Section I: IFSP Meeting Request: Completed by Service Coordinator

<table>
<thead>
<tr>
<th>Date:</th>
<th>Regional Office Fax #</th>
<th>Attn(Scheduler):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child's Initials</td>
<td>EI #:</td>
<td>Family's phone #</td>
</tr>
<tr>
<td>Service Coordinator</td>
<td>SC Phone #:</td>
<td>SC Fax #:</td>
</tr>
</tbody>
</table>

**Type of IFSP:**
- [ ] Interim
- [ ] Initial
- [ ] Initial with Transition Conference
- [ ] Review
- [ ] Review with Transition Conference
- [ ] Amendment
- [ ] Assistive Technology
- [ ] Transition Conference
- [ ] Paper Review of IFSP: No formal meeting requested by parent due to no requested changes to the existing plan (SC must submit a copy of this form with the paper review to the EIOD)

**Date of IFSP:**

**Location of IFSP Meeting (please check one):**
- [ ] Parent Home
- [ ] Agency
- [ ] Regional Office
- [ ] Other location: __________________________

**Address:**

**Phone # (s) of IFSP meeting location:**

**Special Circumstances:**

_Service Coordinator must send written confirmation of the IFSP meeting no later than 2 days before the meeting to:*
- [ ] Parent
- [ ] Eval. Site/Interventionist
- [ ] Foster Care Agency
- [ ] CPSE Administrator
- [ ] Other: ____________________________________________

**Written confirmations must always be sent to the Regional Office within 48 hours of verbal confirmation**

### Section II: Meeting Confirmation: Completed by Regional Office

- [ ] The above IFSP request is confirmed: 
- [ ] The above IFSP request CANNOT be confirmed for the following reasons:

<table>
<thead>
<tr>
<th>Time/Date not available</th>
<th>Other:</th>
</tr>
</thead>
</table>

**Signature**

**Date:**

### Section III: Reschedule: Completed by Service Coordinator

**Previous IFSP meeting was cancelled due to:**
- [ ] Parent
- [ ] Eval. Rep
- [ ] SC
- [ ] EIOD

**Date confirmation sent**

**Parent**

**Eval. Site**

**Foster Care Agency**

**CPSE Administrator**

**Written confirmations must always be sent to the Regional Office within 48 hours of verbal confirmation**

### Section IV: FAX Confirmation of Provider Availability by Phone: Completed by Service Coordinator

**Who will be available by phone?**
- [ ] Eval Site Representative
- [ ] Interventionist
- [ ] CPSE Representative
- [ ] Other

**Phone # (s) of person available by phone:**

_The Service Coordinator MUST notify the RO of the change 24 hrs before the meeting by completing and Faxing Section IV of this form._

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