**IFSP Meeting Request / Confirmation Form**

**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: ___________________________

**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:
  - [ ] Time/Date not available
  - [ ] Other: ___________________________

**Signature** __________________________________________  **Date:** __________________________

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

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

*Service Coordinator must send written confirmation of the IFSP meeting no later than 2 days before the meeting to:*

**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**

**Any person participating by phone is expected to call into the meeting. Providers participating by phone must be available for pertinent portions of the meeting. Provider will forward a signed attestation page to the EIOD during or within 24 hours of the IFSP meeting.**

**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.*