

First Steps
Six Month Eligibility Determination Team Review

Child Name: _____ ID: _____ DOB: _____ Age: _____
 Parent(s) Name: _____ Phone: _____
 Service Coordinator: _____ EdTeam Leader: _____
 IFSP Scheduled: _____ Date: _____ Time: _____ Confirmed: _____
 Place: _____
 (Indicate address if other than home)

Current Services	Provider Name	Frequency	Intensity	Reports attached Y/N

Requests: _____

ED Team to complete:

Summary of progress related to IFSP outcomes:

Documentation of Communication:

Suggestions for other resources not listed:

Recommendations of IFSP Outcomes/Strategies:

Time In: _____ Time Out: _____ Total: _____

_____ I will attend 6-month review

_____ I will not attend 6-month review

 Ed Team Leader's Signature

 Date

Other Team members involved in this review: _____