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| **DEPARTMENT OF HEALTH SERVICES**  Division of Medicaid Services  F-00989P (02/2017) | | **STATE OF WISCONSIN** | | | |
| **INDIVIDUALIZED FAMILY SERVICE PLAN TEAM SIGNATURE** | | | | | |
| Child’s Name | | | Date of Report | | |
| Enter date | | | Enter date | | |
|  | | | | | |
| * I/we have received a copy of and understand the Parent and Child Rights. * This Individualized Family Service Plan (IFSP) reflects the outcomes that are important to my child and family. * I/we give consent for the services described in this IFSP for my child and family. * I understand that this IFSP will be shared with all team members listed below so they can work in partnership on behalf of my family. | | | | | |
| **SIGNATURE** – Parent / Guardian | Date Signed | | | Print Name  Enter date | |
| **SIGNATURE** – Parent / Guardian | Date Signed | | | Print Name  Enter date | |
| **SIGNATURE** – Parent / Guardian | Date Signed | | | Print Name  Enter date | |
| We have worked together with the family to create this IFSP and agree that this plan will guide our work. | | | | | |
| **SIGNATURE** – IFSP Team Member | Date Signed | | | Print Name / Title  Enter date | Phone Number  enter date |
| **SIGNATURE** – IFSP Team Member | Date Signed | | | Print Name / Title  Enter date | Phone Number  enter date |
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