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| **DEPARTMENT OF HEALTH SERVICES**Division of Medicaid ServicesF-00989P (02/2017) | **STATE OF WISCONSIN** |
| **INDIVIDUALIZED FAMILY SERVICE PLAN TEAM SIGNATURE** |
| Child’s Name | Date of Report |
| Enter date | Enter date |
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| * 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.
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| **SIGNATURE** – Parent / Guardian | Date Signed | Print NameEnter date |
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| 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 / TitleEnter date | Phone Numberenter date |
| **SIGNATURE** – IFSP Team Member | Date Signed | Print Name / TitleEnter date | Phone Numberenter date |
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