

**UNDER THRESHOLD ADDENDUM**

(7/06)

*(This form is required for non-FAPTed cases only and substitutes for the IFSP; the form must be updated every six months.)*

**PRIMARY CHILD:** \_\_\_\_\_

**Date Completed:** \_\_\_\_\_

*PLEASE INCLUDE INFORMATION BELOW ON ALL SERVICES FUNDED (e.g. placement services, intensive in-home services, etc.)*

**EXPECTED OUTCOMES:**

What are the measurable long-term intended outcomes? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are the measurable short-term intended outcomes? \_\_\_\_\_

3 months from now: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6 months from now: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SERVICE PROVIDER SELECTION:**

(Briefly outline reasons for selecting current provider(s) over others, including non-CSA options or less costly alternatives explored and specific justification if Medicaid provider was not selected and/or private insurance was not utilized. Was Community Attention considered?)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**TRANSITION PLAN:**

(Briefly outline what is needed to step down/discharge from the current plan, including the anticipated timeframe for the CSA funded services currently being requested, and to what anticipated placement or services, if any, the child and/or family will be transitioned.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**OTHER SERVICES PROVIDED:**

(Briefly outline what, if any, other services, CSA funded or non-CSA funded, are currently being provided to this child and/or family, including services to other children in the household.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_