

NYC EARLY INTERVENTION PROGRAM REQUEST FOR A CHANGE IN FREQUENCY, METHOD, OR LOCATION OR SERVICE CURRENTLY ON AN IFSP

Type or print legibly

Child's Name: _____ D.O.B.: ____/____/____

EI ID #: _____ IFSP Period: From: ____/____/____ To: ____/____/____

Provider Agency Name: Los Niños Services, Inc. Provider ID #: 56900

Name of Person Completing Report: _____

Discipline: _____ Date: ____/____/____

Check as appropriate: Service Type: _____

Request for increase in service: From: _____ To: _____

Request for a decrease in service: From: _____ To: _____

Change in location/method of service: From: _____ To: _____

Request for termination of service. Effective date: _____

Attach most current Provider Progress Report (3 mo, 6 mo, 9 mo, annual)

1. For increase or decrease in service: a) Why is the request being made? b) Why are the current plan and/or strategies not sufficient to meet IFSP Outcomes? c) Have outcomes been met? d) Did this service start when authorized and has it been delivered as authorized on the IFSP?

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2. For termination of service. Explain:

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3. For change in location/method of service: a) why is the request being made? b) Why can't the IFSP outcomes be met in the current location or by the current method? c) Has this service been delivered as authorized?

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I certify that I have provided the above services in accordance with the frequency and duration mandated in the IFSP, and have worked toward addressing the relevant outcomes set forth in the IFSP I further certify that my responses in this report are an accurate representation of the child's current level of functioning.

Signature of interventionist completing report: _____
License No. _____ (If certified interventionist, do not indicate certificate number)