

NYC EARLY INTERVENTION PROGRAM
CHANGE IN SERVICE(S)/SERVICE PROVIDER/SERVICE COORDINATOR

Child's EI ID Number: _____ Child's DOB: ____/____/____
Child's Name: (Last) _____ (First) _____ (MI) _____
Service Coordinator: _____ SC ID #: _____
SC Agency Name: _____ Tel. # _____ Fax # _____

"X" ALL BOXES THAT APPLY – COMPLETE SECTIONS ACCORDINGLY

***SECTION I: SERVICE PROVIDER** (See Note for documentation requirements)
FROM: _____ TO: _____

Provider Name: _____
Provider EI No: _____
Anticipated Date: ____/____/____

***SECTION II: SERVICE COORDINATOR** (See Note for documentation requirements)
FROM: _____ TO: _____

Name: _____
SC ID #: _____
Provider #: _____
Anticipated Date: ____/____/____ Check one: Initial Ongoing

***SECTION III: CHANGE IN SERVICES**

A separate form for each service must be completed when:

- A request is being submitted to change a service type currently on the IFSP (Method, Location, Frequency can all be requested on one form for the same service type.)
- A request to add Ongoing Service Coordination units is being made.
- A request to add a service type is being made.
- A request to terminate a service type is being made

Add Service Type Method Location Termination of Service Frequency/Duration (Mins./Days/Weeks) Add Ongoing Service Coordination Units

Anticipated Date: ____/____/____ Service Type: _____

I have been consulted about the above changes and approve of those changes

Parent/Guardian Signature: _____ Date: ____/____/____

*** Note:** *The service coordinator must do the following:*

1. Providers who are requesting a **termination of a service/ increase in frequency or intensity/change of method** must complete the *Justification for Change in Frequency, Duration, or Method of Services form*.
2. Attach new **IFSP Service Authorization** form reflecting only the amended Service Type(s).
3. If the ongoing service coordination/service provider agency will change, attach a new **IFSP Services Authorization** form.
4. Send the above forms to the EIOD. Changes **are not** official until approved and signed by the EIOD.
5. **All proposed changes, except a change in initial service coordination and a change in provider of services already on an IFSP, must have written parental consent.**

The EIOD will send a copy of the approved form to the current service coordinator (and newly assigned service coordinator, if applicable).

EIOD Section (For Office Use Only): Status of Request

SC agency: Approved Denied (Prior Written Notice Attached) Effective Date of Change (if approved): ____/____/____

Service Provider: Approved Denied (Prior Written Notice Attached) Effective Date of Change (if approved): ____/____/____

Add Service Type: Approved Denied (Prior Written Notice Attached) Effective Date of Change (if approved): ____/____/____

Method: Approved Denied (Prior Written Notice Attached) Effective Date of Change (if approved): ____/____/____

Location: Approved Denied (Prior Written Notice Attached) Effective Date of Change (if approved): ____/____/____

Terminate Service Type: Approved Denied (Prior Written Notice Attached) Effective Date of Change (if approved): ____/____/____

Frequency/Duration Approved Approved in Part (Specify): _____ Denied (Prior Written Notice Attached) Effective Date of Change (if approved): ____/____/____

Add OSC Units: Approved Denied Effective Date of Change (if approved): ____/____/____

EIOD Name (Print): _____ EIOD Signature: _____ Date Signed: ____/____/____