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

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[ ] ***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 <u>only</u> 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: ____/____/____