INDIVIDUALIZED FAMILY SERVICE PLAN
SERVICE AUTHORIZATION FORM Page 5a

CHILD INFO: Child's Name: (Last) _____ (First) _____
(Middle) _____ EI #:_____ DOB: ____/ _____/ _____
Effective Date of IFSP: _____/ _____/ _____ End Date of IFSP: _____/ _____/ _____

TYPE OF IFSP
❑ Interim ❑ Initial
❑ 6 Month
___6 ___18 ___30
❑ Annual
___12 ___24 ___36
❑ Amendment to IFSP
Dated:
_____/_____/_____

PROVIDER INFORMATION (USE ONE SHEET PER SERVICE PROVIDER)
PROVIDER NAME:
_____
PROVIDER EI #: _____
CONTACT PERSON: _____
CONTACT PERSON'S PHONE: (_____) _____
CONTACT PERSON'S FAX: (_____) _____
SC: _____ SC #: _____
PHONE: (_____) _____ FAX: (__)_____

Service Provider not identified at time of IFSP for the following services (Pended):
Service Type: Frequency/ Duration Authorized:
1. _____
2. _____
3. _____
4. _____
5. _____
OSC will identify provider by _____/_____/_____
NOTE: OSC must contact EIOD if provider is not identified within two weeks

EIOD Name _____ DATE: _____/_____/_____
EIOD Signature:

NOTE: The Service Authorization Form is only valid if signed by the EIOD. A separate Service Authorization Form must be completed for each service provider.

Insurance Information must be completed and updated at each IFSP, including amendments. If the child is enrolled in a Medicaid Managed Care Plan, include child's Medicaid number, as well as insurance Company Information.
Child Medicaid Eligible: □ Yes □ No
Child's Medicaid OR CIN #: ___/ ___/ ___/ ___/ ___/ ___/ ___/ ___
Ltr / Ltr / # / # / # / # / # / Ltr

Private Insurance Name (Do not write Child Health Plus)
Insurance Company Name: _____
Policy Holder Name: _____ DOB: ____/ ____/ ____
Relationship to Child: _____Policy #: _____
Group Name: _____Group #: _____
Effective Date: _____/ _____/ _____

1: SERVICE TYPE Use code letters for Service, Method and Location (See back for KEY)		2: Method	3: Location	4: Begin Date	5: End Date	6: Min per visit	7: Days per week	8: Weeks	9: Units	10: Waiver Code(s)		11: Status	Provider Instructions 12: Bilingual Request?	Provider Instructions 13: Prescription Needed?
1: TYPE SVC *Code Letter*	_____	_____	_____							Waiver Code(s)	_____ Initial Start date:	☐ ADD ☐ END	☐	☐ PT ☐ OT ☐ Nursing
2: TYPE SVC *Code Letter*	_____	_____	_____							Waiver Code(s)	_____ Initial Start date:	☐ ADD ☐ END	☐	☐ PT ☐ OT ☐ Nursing
3:TYPE SVC *Code Letter*	_____	_____	_____							Waiver Code(s)	_____ Initial Start date:	☐ ADD ☐ END	☐	☐ PT ☐ OT ☐ Nursing
4: TYPE SVC *Code Letter*	_____	_____	_____							Waiver Code(s)	_____ Initial Start date:	☐ ADD ☐ END	☐	☐ PT ☐ OT ☐ Nursing
5: TYPE SVC *Code Letter*	_____	_____	_____							Waiver Code(s)	_____ Initial Start date:	☐ ADD ☐ END	☐	☐ PT ☐ OT ☐ Nursing

Data Entry Name: _____ *Date:* _____/_____/_____