Nassau County Department of Health Early Intervention Program
IFSP Amendment Request

Child Name:_____ EIOD:_____

Date of Birth:_____ IFSP Period:_____

OSC/Agency:_____

I.

Check off and complete or attach justification for any of the following requests:

- ☐ Supplemental Evaluation Request. Type _____ Agency_____
- ☐ Discharge from Early Intervention Program: *attach Discharge Note*
- ☐ Discharge from a specific service(s) : *attach Discharge Note* Type:_____
- ☐ Change location of service. From: _____ To:_____
- ☐ Change Agency or Independent provider. From:_____ To:_____
- ☐ Change Ongoing Service Coordinator to:

  To: Agency: _____ Name:_____

Justification *(Include requested dates and details)* _____

_____

_____

_____

_____

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_____

II.

Answer questions on form # EI 5093 B in full and attach if requesting any of the following IFSP changes:

- ☐ Change in frequency or duration of service(s). From_____ To_____
- ☐ Add new service. Type:_____

Parent Signature:_____ Date:_____

Therapist/OSC Signature: _____ Date:_____

Changes are official once signed and authorized by EIOD

EI 5093 A 6.6.16