

Nassau County Department of Health

Office of Children with Special Needs - Early Intervention Program

Confirmation of Early Intervention Services

Confirmation of Ongoing Service Coordinator



Child Name: _____ D.O.B. _____

Family Contact Phone Number: _____

Name of EI/OD: _____

Current IFSP From: _____ To: _____

Type of Service (s)	Provider Agency	Freq/Duration	Location	Therapist's Name (If known)	Effective Date (DOH use)

Ongoing Service Coordinator Name: _____ Phone Number: _____

Agency: _____

If services are not in place within 30 days, state reason (s):

Signature of Agency/OSC making confirmation: _____

Date: _____