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 EIOD: _____

Current IFSP From: _____ To: _____

Type of Service (s)	Qualified Personnel	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: _____

EI 5400 Revised 10.13.26