

**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: _____
Duration change: _____ to _____. PMR requested: Yes _____ No _____
- Change Agency or Independent provider. From: _____ To: _____
- Change Ongoing Service Coordinator to:
To: Agency: _____ Name: _____

Justification (*Include requested dates and details*) _____

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