



**NASSAU COUNTY
DEPARTMENT OF HEALTH
OFFICE OF CHILDREN WITH SPECIAL NEEDS
Early Intervention Program**

NOTIFICATION OF NON-DELIVERY OF AUTHORIZED SERVICES

The purpose of this form is to provide written information to the Nassau County Early Intervention Official Designee (EIOD) after telephone contact when the services contained in the IFSP are not being delivered in the manner authorized.

This form is to be used by:

1. an independent contracted service provider or a service provider working for an agency. Either provider **MUST** notify the Ongoing Service Coordinator as soon as:
 - the child has missed three (3) consecutive sessions; or
 - there has been difficulty in delivering the services in the authorized manner.

-OR-

2. the contracted Ongoing Service Coordinator to notify the Nassau County Early Intervention Official Designee as soon as:
 - the child has missed three (3) consecutive sessions;
 - there has been difficulty in delivering the services in the authorized manner; or
 - they anticipate or experience an inability to deliver services contained as written in the child's IFSP. This notice should be forwarded within ten (10) days of the authorized start date of the service.

TO: (Check the appropriate box) Date: ____/____/____

Name of Early Intervention Official Designee

Name of Ongoing Service Coordinator

FROM: (Check the appropriate box and complete the required information)

Service Provider

Ongoing Service Coordinator

Address

(____) _____
Phone Number

(____) _____
Fax Number

RE: Child's Name: _____ DOB: ____/____/____

Check Reason(s) for Contact to EIOD: SERVICE TYPE: _____ AUTH. #: _____

Difficulty delivering services as authorized in the child's IFSP. Auth. Start: ____/____/____ Auth. End: ____/____/____

Inability to deliver services contained in the IFSP. Auth. Start: ____/____/____ Auth. End: ____/____/____

Five (5) consecutive authorized services missed:

<u>Dates of Missed Sessions</u>	<u>Reason(s) for Missed Sessions</u>
1. ____/____/____	_____
2. ____/____/____	_____
3. ____/____/____	_____
4. ____/____/____	_____
5. ____/____/____	_____

AFTER THE PHONE CALL TO THE EIOD NAMED ON THE CHILD'S INDIVIDUALIZED FAMILY SERVICE PLAN, PLEASE DIRECT THIS **NOTIFICATION OF NON-DELIVERY OF AUTHORIZED SERVICES** TO THE EIOD'S FAX.