WESTCHESTER COUNTY DEPARTMENT OF IIEALTI-1
EARLY INTERVENTION PROGRAM
JUSTIFICATION FOR PROPOSED IFSP AMENDMENT

CHILD'S NAME:_____ DOB:_____

El NYEIS ID: _____

NA ME OF PROVI DER/DISCIPLINE:

_____ PHONE#:_____

NAME OF AGENCY (IF APPLICABLE):_____

OSC NAME: DATE SUBMITTED TO

Check as appropriate and address all questions for the proposed IFSP amendments as described in the corresponding number below:

1. Request for Evaluation (type):_____
2. Request for change frequency of service (type):_____ From_____ To_____
   - Authorized Service: _____
   - # of sessions authorized:_____
   - # of sessions completed by Provider:._____
   - # of sessions missed (due to wither provider or parent reasons):_____
3. Request to change intensity (Ind.Group): _____
   From: / / To: / ___ ___
4. Request to duration: Service (type):_____ From,_____ To_____
5. Request to change the length (# of minutes): _____
6. Request to change location:_____
7. Request termination of service (type):_____ End Date:– _____
8. Request for new service (type): _____
9. Request to change ongoing service coordinator agency: From:_____ To:_____
10. Request to add co visit (s): _____

Legend of Terms:
Duration: start date and end date of service to be provided
Frequency: number of days or sessions the service will be provided
Intensity: whether service is provided on an individual or group basis in accordance with the service model option in section 69·4.10 and reimbursed in accordance with 69·4.30 of this subpart
Length: the number of minutes of actual time spent delivering services during each session
Location: the actual place where the services will be delivered

Written justification for amendment to IFSP

All IFSP team members must be involved in the discussion concerning this proposed IFSP amendment.
The following IFSP team member(s) support this proposed IFSP amendment (list name and date consulted):

The following IFSP team members do not support this proposed amend1nent (list name and date consulted):

_____	

I certify that my responses in this report are an accurate representation of the child's current level of functioning.

Signature of professional completing report (discipline):_____ Date:_____

Signature of parent/guardian:_____ Date:

Required justification components: Justification will be returned if all questions are not answered.

1. Strengths and Weaknesses

   a, What is the child's current level of functioning?
   b. What is the parent/provider new concern?

2. Family Involvement;

   a. Describe how you are supporting the family and/or caregivers in integrating suggested activities "1nto the child and family's daily routines.
   b. What successes or difficulties has the family had in integrating these activities

3. IFSP Outcomes:

a. What is/are the functional outcome(s) that you are currently working on as stated in the IFSP?
b What are the short term objectives that you are currently working on to reach the functional outcomes(s)?
c. What progress has the child made toward the IFSP outcomes since initiation of this service plan?
d, Have you coordinated with other team members to achieve IFSP outcomes?
e. Have you addressed the same or d'1fferent IFSP outcomes as other therapist? Explain.

4, Recommended Change:

   a. What will the recommended change offer that the present plan does not?
   b. Does the proposed change n:!commend new functional outcome?
   c. What new, short term objectives are being proposed to reach the functional outcomes?
   d, What are the new strategies being proposed to achieve the short term objectives?

5. List any changes in the child's medical diagnoses, conditions or medications since the last IFSP which may have an impact on the child's response to intervention. Describe how a change in the child's medical condition or medications will affect the services delivery plan.