

**WESTCHESTER COUNTY DEPARTMENT OF HEALTH  
EARLY INTERVENTION PROGRAM  
JUSTIFICATION FOR PROPOSED IFSP AMENDMENT**

CHILD'S NAME: _____		DOB: ____/____/____	
EI NYEIS ID: _____			
NAME OF PROVIDER/DISCIPLINE: _____		PHONE #: _____	
NAME OF AGENCY (if aplicable): _____			
OSC NAME:		DATE SUBMITTED TO OSC: ____/____/____	
OSC PHONE :		EIOD:	
IFSP START DATE: ____/____/____		END DATE: ____/____/____	

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

1. Supplemental for evaluation (discipline): \_\_\_\_\_
2. Request to change frequency of service (type): \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_
  - Authorized Service: \_\_\_\_\_
  - # of sessions authorized: \_\_\_\_\_
  - # of sessions completed by Provider: \_\_\_\_\_
  - # of sessions missed (due to either 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 length (# of minutes): From \_\_\_\_ To: \_\_\_\_ ; Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_
6. Request to change location: From: \_\_\_\_\_ To: \_\_\_\_\_ ; Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_
7. Request termination of service (type): \_\_\_\_\_ End Date: \_\_\_\_/\_\_\_\_/\_\_\_\_
8. Request for new service (type): \_\_\_\_\_ ; Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_
9. Request to change OSC agency: From: \_\_\_\_\_ To \_\_\_\_\_ ; Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_
10. Request to add co visit(s) \_\_\_\_\_ ; Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_
11. Request for additional OSC units (# of units) \_\_\_\_\_ : From \_\_\_\_/\_\_\_\_/\_\_\_\_ To \_\_\_\_/\_\_\_\_/\_\_\_\_

**Legend of Terms:**

**Frequency** - means the number of days or sessions per week, the service will be provided.

**Intensity** - means whether the service is provided on an individual (facility or home/community) or group basis (group, parent/child group, parent/family support group).

**Length** - means the number of minutes of actual time spent delivering services during each session.

**Duration** - means the start date and end date the service is to be provided.

**Location** - means the actual place or places where the service will be delivered.

**Method** - means how a service is provided.

**JUSTIFICATION FOR PROPOSED IFSP AMENDMENT (page 2)**

Written justification for amendment to IFSP. Please see required Justification Components

**OSC to Complete A & B**

- A. 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):

_____	_____
_____	_____
_____	_____

B. The following IFSP team members do not support this proposed amendment (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: \_\_\_\_\_

Has the parent requested an IFSP Amendment meeting to discuss proposed changes?

YES NO. If yes, EIOD will schedule meeting; time, location and date convenient to the parent

**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 in to 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 different 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 recommend 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.