NYC EARLY INTERVENTION PROGRAM
JUSTIFICATION FOR CHANGE IN FREQUENCY, INTENSITY OR METHOD OF SERVICES

Child's EI ID Number: ______________________ Child's DOB: ____/____/____

Child's Name: Last______________________First______________________

Name of Provider:______________________ Discipline:______________________

Therapist Phone Number: (______)______________________ Agency Name: ______________________

Name of Supervisor: ______________________Supervisor Phone Number: (__________) ______________________

Date of Submission to OSC: ______________________

Authorization Information: All areas must be completed on this form or it will be returned as incomplete.

IFSP Start Date: _____/_____/_____ IFSP End Date: _____/_____/_____ Authorized Service: ______________

# of sessions authorized: ______________

# of sessions delivered by provider prior to this **Justification for Change**: ______________

# of sessions missed (due to either provider or parent reasons): ______________

Date(s) of any **Previous Justification for Change** in this Discipline: ____/____/____

Request for Change (Complete all that apply): ☐ Termination of Service ☐ Increase/Change in Service

☐ Frequency: From: times per To: times per

☐ Duration: From: minutes To: minutes

☐ Method: From: To:

Required Justification Components: Justifications will be returned if all questions are not answered. Responses must be numbered and addressed in the below order. For termination of service(s), complete sections 1, 2, and 5 only.

1. Current Function:
   a. What is the child's current level of function?
   b. If an evaluation was administered, provide the name of the test and the score, unless this information is included in an evaluation report.
   c. What was the child's level of function at the last IFSP?
   d. What can the child do now, that he/she was unable to do previously (give skill-based examples).
2. Service(s) Provided to Date:
   a. When did you begin delivery of the service?
   b. Did a different provider deliver these services before you were assigned?
   c. Did service(s) begin on time?
   d. Explain any gaps in service(s) including: missed sessions, frequent illness, vacations etc. Include both provider and family reasons when available.
3. Family Involvement:
   a. Describe how you are supporting the family and/or caregivers in integrating suggested activities into the child's and family's daily routines (Describe specific activities).
   b. What successes or difficulties has the family had in integrating these activities?
   c. When suggested activities were integrated into everyday activities, what changes in the daily routines have you observed?
4. Service Plan Coordination
   a. Have you coordinated with other team members to achieve IFSP outcomes?
   b. Have you addressed the same or different IFSP outcomes as other therapists? Explain.
5. 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 outcome(s)?
   c. What progress has the child made toward the IFSP outcomes since initiation of this service plan?
   d. What alternate strategies have you used to replace ineffective strategies? Have they been effective?
6. What will the recommended change offer that the present plan does not?
   a. Does the proposed plan recommend a new functional outcome?
   b. What new, short term objectives are being proposed to reach the functional outcomes?
   c. What are the new strategies being proposed to achieve the short term objectives?
   d. Will the new plan involve strategies and methods that cannot be reinforced by activities that are part of the child's daily routine? If yes, describe why and indicate if changes in the daily routine are possible.
7. 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 reaction to EI Services. Describe how a change in the child's medical condition or medications will affect the service delivery plan.

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GENERAL DIRECTIONS

This form is to be used for a change(s) in a **service already on an IFSP**, not to request a new service or a change to service coordination units.

- The therapist/teacher must complete this form and submit it to the Ongoing Service Coordinator (OSC) when there is a proposed termination to, or change in frequency, duration or method of a service currently on an IFSP.
- The OSC must submit this form to the Regional Office with other required paperwork whenever there is a request for a change in frequency, intensity or method of a service in the IFSP, (please refer to Amendment Policy in this chapter).

DEMOGRAPHIC INFORMATION

Please fill out this section in its entirety. The name and contact information of the therapist's supervisor must be indicated.

AUTHORIZATION INFORMATION

This section **must** be completed in its entirety. Incomplete **Justifications** will be returned to submitter.

1. IFSP Start Date: ______/______/______ IFSP End Date: / /	Copy the Begin and End dates from the upper left hand corner of the IFSP being amended.
2. Authorized Service:	Indicate IFSP service type being amended.
3. # of sessions authorized:	Copy the # of session units authorized from the IFSP.
4. # of sessions completed by Provider:	Provide the total number of sessions that were delivered (include any make-up sessions).
5. # of sessions missed (due to either provider or parent reasons):	Indicate the number of any sessions missed, (exclude any sessions that were made-up).
Date of Previous Justification(s) for Change in this Discipline: If there were prior requests to amend this service, indicate the date of request.	
Request for Change: Indicate all changes to this service that are being requested at this time.	
Required Justification Components: For requests to **terminate services or decrease frequency**, complete questions 1, 2, and 5 only. For **all other requests**, answer questions 1 through 7.	