

NYC EARLY INTERVENTION PROGRAM

Date: _____

Letter of Justification

Request for: _____

Child's Name: _____

D.O.B.: _____ EI #: _____

Provider Agency Name: Therapeutic Resources Physical Therapy, LLP Provider ID#: 59700

Name of Interventionist Completing the Report: _____

Discipline: _____

I- **CURRENT FUNCTIONING** (outcomes worked and met, child's response to services):

II- **CONCERNS/REASONS FOR REQUEST** (explain reason to request an additional evaluation):

III- **RECOMMENDATIONS** (rational for request):

I certify that I have provided the above services in accordance with the frequency & duration mandated in the IFSP, and have worked toward addressing the relevant outcomes set forth in the IFSP. I further certify that my responses in this report are an accurate representation of the child's current level of functioning.

Signature of Clinician: _____ **License No.** _____