

**NYC EARLY INTERVENTION PROGRAM
REQUEST FOR CHANGE IN FREQUENCY, METHOD OR LOCATION
OF SERVICE CURRENTLY ON AN IFSP**

Child's Name: _____ DOB: ____/____/____
EI ID #: _____ IFSP Period: From: ____/____/____ To: ____/____/____
Provider Agency Name: Therapeutic Resources Physical Therapy, LLP Provider ID #: 59700
Name of Person Completing Report: _____
Discipline: _____ Date: ____/____/____

Check as appropriate: Service Type: _____
() Request for increase in service: From: _____ To: _____
() Request for a decrease in service: From: _____ To: _____
() Change in location/method of service: From: _____ To: _____
() Request for termination of service. Effective Date: _____
*Attach most current Provider Progress Report (3 mon., 6 mo., 9 mo., annual)

1. For increase or decrease in service: a) Why is the request being made? b) Why are the current plan and/or strategies not sufficient to meet IFSP outcomes? c) Have outcomes been met? d) Did this service start when authorized and has it been delivered as authorized on the IFSP?

2. For termination of service. Explain:

3. For change in location/method of service: a) Why is the request being made? b) Why can't the IFSP outcomes be met in the current location or by the current method? c) Has this service been delivered as authorized?

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 interventionist completing report: _____
License No. _____ **(If certified interventionist, do not indicate certificate number)**