

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

CHILD'S NAME: _____ DOB: _____
NAME OF PROVIDER/DISCIPLINE: _____
NAME OF AGENCY (if applicable): _____
OSC: _____
EIOD: _____
IFSP PERIOD: From: _____ To: _____

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

- |   |   |
|---|---|
| <p>1. <input type="checkbox"/> Request for evaluation (type): _____</p> <p>2. <input type="checkbox"/> Request for increase in service (type): _____</p> <p>3. <input type="checkbox"/> Request for decrease in service (type): _____</p> <p>4. <input type="checkbox"/> Change in location/method of service</p> <p>5. <input type="checkbox"/> Request for termination of service</p> | <p>6. <input type="checkbox"/> Request for new service (type): _____</p> <p>7. <input type="checkbox"/> Request for ATD (type): _____</p> <p>8. <input type="checkbox"/> Request for Respite Services</p> <p>9. <input type="checkbox"/> Request for Group Developmental Model</p> <p>10. <input type="checkbox"/> Other: _____</p> |
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<p><b>1. Evaluation:</b> a) Why is the request being made? b) Why are the current strategies not meeting the IFSP outcomes? c) Identify why the child's developmental level in the selected domain is warranting an evaluation.</p> <p><b>2. and 3. Increase or decrease in service</b> (use those that apply): a) Why is the request being made? b) Why is the current plan and/or strategies not sufficient to meet IFSP outcomes? c) Have the outcomes been met? d) Did the service start when authorized and has it been delivered as authorized on the IFSP? e) How will an increase in the service help to better meet the IFSP outcomes?</p> <p><b>4. Change in location/method of service:</b> 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? d) How will a change in the location/method of the service help to better meet the IFSP outcomes?</p> <p><b>5. Termination of service</b> (explain): Review the progress that has been made, and the child's current developmental status.</p> <p><b>6. Request for new service:</b> a) Why is the request being made? b) Why can't the IFSP outcomes be met with the current services? c) How will this new service help to better meet the IFSP outcomes?</p> <p><b>7. Request for ATD:</b> a) Why is the request being made? b) What functional outcomes are unable to be met without the ATD? c) How will the child's developmental level be enhanced? d) How will the ATD impact the outcomes? e) What alternatives have been considered? f) Has the child's physician been consulted (with parental consent)?</p> <p><b>8. Request for Respite Services</b> (must be accompanied by "Request for Respite Services" form)</p> <p><b>9. Request for Group Developmental Model:</b> a) How would a group experience help to meet the functional outcomes identified in the child's IFSP? b) What are the child's unique strengths, developmental needs and skills, interests, health status and history that contribute to the consideration of a group setting? c) Considering the child's chronological age and developmental status, in what ways might s/he benefit from participating in group services? d) What approaches and activities in a group setting will support the transition of the child to a typical/special education preschool program? e) If child has health issues, what precautions and supports are necessary to ensure the child's health status will not be compromised in a group setting? What types of adaptations, modifications, supports, and equipment might be needed to enhance the child's participation in the group setting?</p> <p><b>10. Other:</b> Describe the type of amendment to the current IFSP that is being proposed and the reason(s) for requesting this change.</p>
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JUSTIFICATION FOR PROPOSED IFSP AMENDMENT (page 2)

Written justification for change of service:

**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 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: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of parent/guardian: \_\_\_\_\_ Date: \_\_\_\_\_

