

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

Child's EI ID Number: \_\_\_\_\_  
 Child's Name: Last: \_\_\_\_\_  
 Name of Provider: \_\_\_\_\_  
 Therapist Phone Number: \_\_\_\_\_  
 Name of Supervisor: \_\_\_\_\_  
 Date of Submission to OSC: \_\_\_\_\_

Child's DOB: \_\_\_\_\_  
 First: \_\_\_\_\_  
 Discipline: \_\_\_\_\_  
 Agency name: Theracare  
 Supervisor Phone Number: \_\_\_\_\_

**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?

If an evaluation was administered, provide the name of the test and score, unless this information is included in an evaluation report.

b. What was the child's level of function at the last IFSP?

c. 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 service?

b. Did a different provider deliver these services before you were assigned?

c. Did Services 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.

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 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?

What new, short term objectives are being proposed to reach the functional outcomes?

- b. What are the new strategies being proposed to reach the functional outcomes?
- c. 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 effect the service delivery plan.**

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