HEALTH DEPARTMENT
Children's Services Unit

Amendment to ISFP Form

To: _____ From: _____
(Name of service coordinator) (Name of therapist)

Child's Name: _____ DOB: _____

Amendment requested: _____
_____
_____

Justification/reason for the amendment (be specific):_____
_____
_____
_____

Did you discuss this amendment request with the parent? _____ Yes _____ No
(The service coordinator will still call the parent to discuss the request)

Signature of Therapist: _____ Date: _____

OFFICE USE ONLY
Action requested: _____
_____
_____

Parent requested the change: _____ Parent aware and receptive of the change: _____
Other comments: _____

Signature of service coordinator: _____ Date:_____

Action taken by Early Intervention Official:

_____ Request approved Effective date: _____

_____Request disapproved Reason for disapproval: _____

_____ _____
EARLY INTERVETION OFFICIAL/DESIGNEE DATE

*Parents: If you disagree with the changes being made to the IFSP or with the decision of the early intervention official, you may discuss your options with your service coordinator. You may also ask for mediation, an impartial hearing, or file asystem complaint. These rights and procedures are described in *A PARENT'S GUIDE* booklet. If you need an additional copy of this booklet, please contact your service coordinator.

Copies of this change are being sent to:
Parent _____ Provider(s) (list below) _____ Physician _____
_____ _____
_____