CONFIDENTIAL

Child ID# | County

NJEIS INDIVIDUALIZED FAMILY SERVICE PLAN REVIEW SERVICE UPDATE PAGE

Child's Last Name | Child's First Name | MI | Birthdate | Service Coordinator Name

IFSP Start Date | IFSP Review Date | IFSP Review Type

☐ 3 Month ☐ 6 Month ☐ Family Request ☐ System Request

☐ New Service ☐ Modified Service Authorization(s) Cancelled | Related Outcome(s)

Provide a rationale to continue, modify, add or discontinue a service including documentation of progress expected or resulting toward the outcome in the IFSP identified above. (If additional space is needed, note it and attach it to this page.

Early Intervention Service

☐ Assistive Technology	☐ Family Training/Counseling	☐ Nutrition	☐ Vision
☐ Assistive Technology Device	☐ Health	☐ Occupational Therapy	☐ Social Work
☐ Audiology	☐ Medical Evaluation	☐ Physical Therapy	☐ Speech/Language Therapy
☐ Developmental Intervention	☐ Psychological	☐ Other Specify	

Check any support listed below that is necessary to the provision of a service listed above.

☐ Assistive Technology Services	☐ Nursing	☐ Transportation	☐ Translation/Interpretation
☐ Assistive Technology Device	☐ Respite/Child Care	☐ Escort	☐ Sign Language Interpretation

Location

- ☐ EC Inclusive Program-EI Provider
- ☐ EC Inclusive Program-Community
- ☐ Home
- ☐ * Service Provider/Clinic
- ☐ * EC Program - Children with Disabilities
- ☐ * Residential
- ☐ * Hospital In-Patient
- ☐ Other Specify

Method

- ☐ Consultation
- ☐ Individual
- ☐ Group
- ☐ Team Meeting

Payer

- ☐ NJEIS System of Payment
- ☐ DDD
- ☐ WIC
- ☐ Other Specify

Intensity/Frequency

Service is provided _____ times every _____ for ____hours and ____minutes.

☐ Each Visit ☐ Total Time

Duration of Service (MM/DD/YYYY)

Projected Start Date | Projected End Date

For each * location checked, explain why the outcome cannot be achieved satisfactorily in a natural environment.

☐ **DECLINE**

I am fully aware of the nature of this service being offered for my child and that I must give written consent. I choose to decline this service from the NJEIS & I acknowledge agreement by the team, that it is needed for my child & family. I understand that I am refusing this service, as agreed, for reasons I have chosen and that I may change my mind and, if so, will contact my service coordinator. I also understand that declining this service does not jeopardize any other early intervention service(s) my child or family receives through the NJEIS.

Parent Signature | Date Signed

☐ **DISCONTINUE**

I choose to discontinue this current service from the NJEIS for the reason(s) checked below.

I choose the effective date of:

Parent Signature | Date Signed

Authorization # | Authorization # | Authorization #

Reason(s) Declined or Discontinued

☐ Insurance Access ☐ Family Cost Share ☐ Family Circumstances ☐ Disagreement with Service ☐ Modified Service ☐ Other

Describe Other:

For NJEIS Provider Use only ☐ **Additional Practitioners submitted on Practitioner Information Form**

Agency Assigned | Date Assigned | Practitioner Assigned/Role | Date Assigned