SUFFOLK COUNTY DEPARTMENT OF HEALTH SERVICES
DIVISION OF SERVICES FOR CHILDREN WITH SPECIAL NEEDS

IFSP REVIEW

Date: ____/____/____

Name of Child: _____
(Last) (First) (MI)

Effective Dates of Current IFSP: From _____/_____/_____ To: _____/_____/_____

Name of EIOD: _____

On the date above, a review of this child's Early Intervention services took place. As a result of this review, the following is to take place:

Check:

( ) Six month review of existing IFSP.
Continue outcomes, strategies and services as authorized to
_____/_____/_____.

( ) Continue existing IFSP - Extend Service Delivery Dates.
New Dates From ____/____/____ To ____/____/____.

( ) Change of Ongoing Service Coordinator to
_____/_____.
(Name) (Agency if applicable)

I have participated in this review and I am in agreement.

* _____ _____/_____/_____
Parent/Guardian/Surrogate Date

* _____ _____/_____/_____
Early Intervention Official Designee Date

*Please sign at the (*) and return both the white and yellow copies to the Early Intervention Official Designee in the enclosed stamped, self-addressed envelope.

Division of Services for Children with Special Needs ♦ 50 Laser Court ♦ Hauppauge, New York 11788
Phone (631) 853-2318 ♦ FAX (631) 853-2350

DSCSN Form 10 C:\Forms\ifsprev3.br.7/01
Distribution: White: Division Yellow: Patent/Guardian Pink: Unsigned Copy in Child's File
18-1456.. 04/04kd