NEW YORK CITY DEPARTMENT OF
HEALTH AND MENTAL HYGIENE

Queens Regional Office
90-27 Parsons Blvd 2nd Floor
P: 718-480-2249 / F: 718-291-1710

IFSP Meeting Request / Confirmation Form

Section I: IFSP Meeting Request: Completed by Service Coordinator		
Date:	Regional Office Fax # 718-291-1710	Attn(Scheduler):
Child's Initials	EI #:	Family's phone #
Service Coordinator	SC Phone #:	SC Fax #:

Type of IFSP: Initial **or** ☐ **Paper Review of IFSP: No formal meeting requested by parent due to no requested changes to the e plan (**SC must submit a copy of this form with the paper review to the EIOD**)**

Date of IFSP: _____ **Location of IFSP Meeting:** Other:

Time of IFSP:_____ **Address:** _____

Phone #(s) of IFSP meeting location : _____

Special Circumstances: _____

Service Coordinator must send written confirmation of the IFSP meeting no later than 2 days before the meeting to:

☐ Parent ☐ Eval. Site/Interventionist ☐ Foster Care Agency ☐ CPSE Administrator ☐ Other: _____

Written confirmations must always be sent to the Regional Office within 48 hours of verbal confirmation

Section II: Meeting Confirmation: Completed by Regional Office

☐ **The above IFSP request is confirmed** ☐ **The above IFSP request CANNOT be confirmed (Select reason):** Other:

Signature _____ **Date:** _____

Section III: Reschedule: Completed by Service Coordinator

Previous IFSP meeting was cancelled due to: ☐ **Parent** ☐ **Eval. Rep** ☐ **SC** ☐ **EIOD**

Service Coordinator must send written confirmation of the IFSP meeting no later than 2 days before the meeting to:

Date confirmation sent _____ ☐ **Parent** ☐ **Eval. Site** ☐ **Foster Care Agency** ☐ **CPSE Administrator**

Written confirmations must always be sent to the Regional Office within 48 hours of verbal confirmation

Section IV: FAX Confirmation of Provider Availability by Phone: Completed by Service Coordinator

Any person participating by phone is expected to call into the meeting. Providers participating by phone must be available for pertinent portions of the meeting. Provider will forward a signed attestation page to the EIOD during or within 24 hours of the IFSP meeting.
Who will be available by phone?

☐ **Eval Site Representative** ☐ **Interventionist** ☐ **CPSE Representative** ☐ **Other** _____

Phone #(s) of person available by phone: _____

The Service Coordinator MUST notify the RO of the change 24 hrs before the meeting by completing and Faxing Section IV of this form.