Nassau County Department of Health
EARLY INTERVENTION PROGRAM
SERVICE PLAN SCHEDULE

Child's Name:_____ **Team Leader:**_____ **Telephone:**_____

ABA COMPETENCY REQUIREMENTS COMPLETED **ANTICIPATED START DATE:**

IFSP PERIOD:_____- _____

_____
(signature of authorizing personnel) **EFFECTIVE DATE:**

MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		SUNDAY	
Service Time	Agency Provider	Service Time	Agency Provider	Service Time	Agency Provider	Service Time	Agency Provider	Service Time	Agency Provider	Service Time	Agency Provider	Service Time	Agency Provider

OSC: _____ **EIOD:**_____

ALL CHILD'S SERVICES ARE TO BE INCLUDED.
SERVICE TYPES: ABA, FT, OT, PT, ST, SW, Nutrition, Groups