Form EI-16

State use only:
EI-16 received:
Reviewed by:
CMACS #:
Entered into CMACS:
Email sent:

Today's date

Child's name

ETID number

Child's DOB

Payment for Early Intervention (EI) Services

Parent name			Parent name		
Address			Address		
City	State	ZIP	City	State	ZIP
Social Security Number	Relationship to child		Social Security Number	Relationship to child	
Home phone	Work phone		Home phone	Work phone	

EI Service Coordinator's name	EI Service Coordinator's email

Name of provider agency: **County:**

Able to pay? ☐ **Yes** ☐ **No** **Child's gender:** ☐ **Male** ☐ **Female**

Family consented to use of public or private insurance? ☐ **Yes (please attach EI-05)** ☐ **No**

Are services provided in the natural environment? ☐ **Yes** ☐ **No** **Most recent initial/annual IFSP Date:**

Recommended IFSP Early Intervention Services (add additional pages if necessary)

IFSP type: ☐ Initial ☐ Annual ☐ Periodic ☐ EI-16 Resubmission

Mark Recommended Services	EI Service	Frequency (ie: 8 x 45 mins/180 days	IFSP Signature Date	IFSP End Date	State Use Only	
					SVC Category	Units
☐	Eval/Assessment				43 ☐ 07 ☐	
	Team/IFSP meetings				EICAT1	
☐	Speech/OT Feeding Therapy				ST	
☐	Speech				THER	
☐	OT					
☐	PT					
Quote attached? ☐	Assistive Tech					
☐	EI service not listed:					

State notes only

Department of Children & Youth

Help Me Grow Early Intervention