NYC EARLY INTERVENTION PROGRAM
REQUEST FOR SIGN LANGUAGE INTERPRETER FORM
FOR IFSP/OTHER MEETINGS

Instructions: To make a request, this form must be completed and faxed to Consumer Affairs at 347-396-8977 or sent via the Health Commerce System to HIN ID: FB452599 **seven (7) business days** before the meeting/event.

Notification of cancellation for any reason MUST be made by the Service Coordinator **no later than 48 HOURS** before the date of the IFSP/other meeting by contacting Consumer Affairs at 347-396-6828 and sending communication via the Health Commerce System to HIN ID: FB452599.

I. Individualized Family Service Plan (IFSP)/Other Meeting Information	
Is this an Initial IFSP meeting? ☐ Yes ☐ No If No, specify the type of event:	
Was this meeting rescheduled from an earlier date? ☐ Yes ☐ No	
Date of this Meeting	
Time: From: To:	Location: Note: IFSPs with sign interpreter must be in person.
II. Child Information	
Child's Name:	
EI ID Number:	DOB:
Name of Deaf Individual:	Relationship to child:
III. Service Coordinator (SC) Information	
SC Name:	
SC Agency:	
SC Telephone #:	SC Email:
IV. Individual to be Contacted the Day of the Meeting	
Name:	
Telephone #:	Email: