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