SUFFOLK COUNTY DEPARTMENT OF HEALTH
Division of Services for Children with Special Needs

Late Services Notice

Date: ______________________________

To: ________________________________
(EIOD's Name)

From: ______________________________

Phone:______________________________

Subject: Services that will start 21 days after the date of the IFSP meeting

Child's Name: ______________________________DOB:_________________

Service Authorized: __________________________

Start Date: _________________________________

Frequency and Duration: ______________________

Location where services are to be provided:
- ☐ Home* __________________________________
- ☐ Office
- ☐ Other (please list**) ____

Reason for the delay: ____

*For home based services please list the town where the family lives
**Please list location and town. For example: Kinder Care, Holbrook

DATE SERVICES FILLED: ___________________________________

Agency that filled services: ___________________________________

For office use only:

Date request received ____________________________

Date services filled ______________________________