NCES PLAN OF CARE

Child's Name: **DOB:** **Gender:**

ESID#: **Medicaid Number:** **Eligibility Date:**

IFSP Date: **Authorization Period:** **Start Date:** **End Date:**

ICD 10 Code and Medical Diagnosis/Description:

Early Interventionist Name: **Service Coordinator:**

Areas Addressed:

Gross motor ☐	Fine motor ☐	Social-Communication ☐
Cognitive ☐	Social-Emotional ☐	Adaptive/Self-help ☐
Vision ☐	Hearing ☐	Behavior ☐

Outcome(s) For Authorization Period:

Goal(s) to Reach Outcome for Authorization Period:

Strategies/Activities to Reach Goal(s) for Authorizations Period:

Procedure Code: **Service Frequency:** **Service Length:** **Service Location:**

Medical Necessity: If child is a Medicaid recipient, the services reimbursed by Medicaid Must be medically necessary (Refer to IFSP Form G)

I am in agreement with the proposed Plan of Care and authorize the Plan:

Licensed Professional Name/Agency: **Professional Credential and License #:**

Licensed Professional Signature: **Date:**

Early Interventionist Signature: **Date:**