SERVICE PROVIDER PLAN / AGREEMENT AMENDMENT

_____ CDSA

1. Date Services to Begin (if submitting new Provider Agreement): ____/____/____
2. Name of Service Provider Agency: _____
3. Mailing Address: _____
4. Telephone #: (____) ____-____ Cellular Phone #: (____) ____-____ Fax #: (____) ____-____
5. Primary contact person: _____ Email: _____
   Alternate contact person: _____ Email: _____

Service Provider Plan:

COUNTY	ITP SERVICE(S)*	PROJECTED CAPACITY**

*Indicate any of the following: PT, OT, SP, Special Instruction (CBRS), AUDIO
**Indicate maximum number of ITP children/families you are able to serve in this county per service at any given time

_____ _____
Printed Name of Authorized Representative — Name of Service Provider Organization

_____ _____
Signature of Authorized Representative — Date of Signature

_____ _____
Signature of CDSA Finance Officer — Date of Signature

_____ _____
Signature of CDSA Director — Date of Signature

Send Plan / Agreement Amendment to: _____
_____
_____
_____

For CDSA Use Only

Date Initial Agreement Effective	
Effective Period of Renewal #1	
Effective Period of Renewal #2	
Agreement Termination Date	
OIG check	
Background Check (Independent Practitioners & Rostered Agency Owners Only)	