

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 _____
Cancellation Policy Received _____
OIG check _____
Background Check _____
(Independent Practitioners & Rostered
Agency Owners Only)