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 / ZIP CODE	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

Insurances current? Prof / Gen / WC / Auto	Y ☐ / N ☐
Date Initial Agreement Effective	
Effective Period of Renewal #1	
Effective Period of Renewal #2	
Agreement Termination Date	
Background/OIG check	