



## Prior Written Notice Form



Child's Name: \_\_\_\_\_ Child's Date of Birth: \_\_\_\_\_

Parent(s) Name(s): \_\_\_\_\_  
\_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code +4 \_\_\_\_\_

The New Mexico Family Infant Toddler (FIT) Program is required to provide you with prior written notice at least five (5) days before any of the following activities take place and to obtain your consent (approval) before they occur:

**This form provides you notice of the following (Check all that apply):**

- |   |  |
|---|--|
| <input type="checkbox"/> A screening of your child's development. <i>(See details below)</i><br><i>Note: You may still request a full evaluation, even if screening indicates that an evaluation is not needed.</i> | <input type="checkbox"/> A meeting to develop / review your Individualized Family Service Plan (IFSP). <i>(See details below.)</i> |
| <input type="checkbox"/> An evaluation/assessment of your child's development. <i>(See details below)</i>   | <input type="checkbox"/> The frequency or location of your services is being changed. <i>(See details below and attached IFSP)</i> |
| <input type="checkbox"/> Your child has been determined to be:<br><input type="checkbox"/> <u>eligible</u> <input type="checkbox"/> <u>not eligible</u> for the FIT Program.  | <input type="checkbox"/> Other (describe): _____   |
| <input type="checkbox"/> A transition conference meeting <i>(See details below.)</i>  |  |

The reason this action is being proposed:

Planned meeting/activity date:	Planned meeting/activity time:	Planned meeting/activity location:
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Family Service Coordinator (FSC) completing form:	Provider agency:
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<input type="checkbox"/> Notice given in person <input type="checkbox"/> Notice sent by mail. (Date mailed _____ )	Signature of Family Service Coordinator
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**TO BE COMPLETED BY THE PARENT(S)** (Please check all that apply):

- ☐ I / we agree to the activity(ies) / changes / services listed above.
- ☐ I / we agree that the above activity(ies) may take place before the required 5-day prior notice (if applicable).
- ☐ I / we have received a copy of our family rights under the FIT Program, including the right to submit a complaint, request mediation or request a hearing. These rights have been explained to me by my Family Service Coordinator.

**ONLY IF THERE IS AN INCREASE IN EARLY INTERVENTION SERVICES** *(frequency, length, duration, or intensity):*

- ☐ I / we agree that the NM FIT Program may bill our child's ☐ private insurance ☐ Medicaid (check which applies) for the early intervention services we receive and understand that we will not be charged a co-pay or deductible. I also understand that I may withdraw consent at any time.

Signature of Parent:	Date:
Signature of Parent:	Date: