SUFFOLK COUNTY DEPARTMENT OF HEALTH
DIVISION OF SERVICES FOR CHILDREN WITH SPECIAL NEEDS
EARLY INTERVENTION PROGRESS REPORT ( ) 3 Month ( ) 6 Month ( ) Discharge ( ) Transition

Child's Name: _____Auth. #_____ DOB: _____
IFSP Period: From: _____ To:_____ Agency Name (if applicable):_____
Name of Provider: _____ Discipline: _____
Name of EIOD: _____ Name of OSC: _____

Date you started working with this child: _____ Frequency/Duration: _____
Where have services been delivered? _____
Number of units authorized: _____ Number of units utilized: _____
Number of units not utilized due to:
Child illness/family vacation: _____ Therapist illness/scheduling: _____
Has a parent/caregiver been present for the sessions? If not, how have you communicated with the family?

IFSP FUNCTIONAL OUTCOMES (For each outcome, rate the progress in this time period: NP-No Progress; LP – Limited Progress; GP – Good Progress; OA – Outcome Achieved. Also include short-term objectives that are being worked on to achieve IFSP functional outcome.):

Describe the strategies the family/caregiver have been taught to use to achieve each outcome and how these strategies are being incorporated into the child's daily routines (e.g. mealtime, bath time, circle time, snack time etc.) Which family member(s) / caregiver(s) have you been working with? (For center-based services identify how you are communicating strategies for carryover.)

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Child's Name: _____ IFSP from _____to_____

In addition to working with the family, describe all collaborative efforts made to address the IFSP outcomes of this child. Examples: Interactions with medical providers, other EI providers, day care staff, other caregivers, community resources (written consent is necessary)

Please provide an assessment of the child's current level of functioning and progress made towards achieving outcomes. This ongoing assessment may include standardized testing. Observations from the parent(s) or caregiver(s), clinical opinion and professional judgement should be included in this assessment.

Recommendations of provider or treatment team: Include information which supports this recommendation.

I certify that I have received and reviewed a copy of the child's IFSP prior to starting services, have provided services in accordance with the IFSP service's specified frequency and duration and have worked towards addressing the relevant IFSP outcomes. I further certify that my responses in this report are an accurate representation of the child's current level of functioning.

Signature of Provider completing report: _____Date:_____

Discipline: _____License #_____

Written Prior Notice: I agree with the therapist who provided this service to my child and assessed my child's current level of development that my child is no longer in need of this early intervention service. I have a copy of my family rights.

Parent's Signature: _____ Date: _____ Last Day of Service:_____

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