SUFFOLK COUNTY DEPARTMENT OF HEALTH
DIVISION OF SERVICES FOR CHILDREN WITH SPECIAL NEEDS
EARLY INTERVENTION PROGRESS REPORT

☐ **6 Month** ☐ **Annual** ☐ **Discharge** ☐ **Transition** ☐ **Change in Provider**

Child's Name: _____EI HUB #_____DOB: _____
Authorization # _____
IFSP Period: From: _____To:_____Agency Name (if applicable):_____
Name of Provider: _____Service Type: _____
Provider Phone Number: _____
Name of EIOD: _____Name of OSC: _____

Date you started working with this child: _____Frequency/Duration: _____
How are the services provided: In person _____ Telehealth _____
Where have services been delivered? _____
Number of units utilized as of the date of this report : _____

If there are any gaps in service delivery (i.e., 3 or more consecutively scheduled visits), describe length and reason for gap in service delivery.

Has a parent/caregiver been present for the sessions? If not, how have you communicated with the family?

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).

*****ALL OUTCOMES MUST BE DISCUSSED AND TAKEN DIRECTLY FROM THE IFSP*****

IFSP OUTCOME(S):

RATE OF PROGRESS IN THIS TIME PERIOD

List the embedded strategies shared with the family toward this outcome

No Progress	Limited Progress	Good Progress	Outcome Achieved
☐	☐	☐	☐

IFSP OUTCOME(S):

RATE OF PROGRESS IN THIS TIME PERIOD

List the embedded strategies shared with the family toward this outcome

No Progress	Limited Progress	Good Progress	Outcome Achieved
☐	☐	☐	☐

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RATE OF PROGRESS IN THIS TIME PERIOD

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All therapists must provide a brief overview **(1-2 sentences)** of the child's current level of ability in **every** developmental domain listed below. In the next section, provide a detailed narrative within your area of specialty describing how the child is responding during sessions.

Adaptive:

Cognitive:

Communication (receptive and expressive abilities):

Physical (gross motor and fine motor):

Social Emotional:

Provide a detailed and descriptive narrative of the child's development within your area of specialization. Please include strengths and needs from what was observed during sessions (include progress to date since the initiation of services). Explain how progress has been determined. This may include observations from the parent(s) or caregiver(s), clinical opinion, and professional judgment. **(If more space is needed, please continue to the following page).**

Additional Space for narrative (if needed).

RECOMMENDATION FOR IFSP PLAN:

No change recommended to service plan or IFSP	Recommended change to service or IFSP	Transition to CPSE	Recommended Discharge
☐	☐	☐	☐

If changes are recommended to the plan, please provide a justification. In this section, please also provide projected/amended goals for the upcoming IFSP period

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: _____ NPI # _____

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: _____