**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.):

What home/school routine activities are you and the family/caregivers using to achieve **EACH** outcome (ex: mealtime, bath time, circle time, snack time, etc.). Describe how interventions are being incorporated into the routine activities. Which family members/caregivers have you been working with? (For center-based services identify how you are communicating strategies for carryover with the family).

 **SUFFOLK COUNTY EARLY INTERVENTION PROGRESS REPORT**

**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)

Based on your ongoing assessment of the child’s progress, what is the current level(s) of functioning? Every 6 months please include testing results and date of testing.

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 have been informed by my child’s provider and agree that my child is no longer in need of the above Early Intervention Service provided by Suffolk County. I have a copy of my family rights.**

**Parent’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **October 2013**