SUFFOLK COUNTY DEPARTMENT OF HEALTH SERVICES
BUREAU OF SERVICES FOR CHILDREN WITH SPECIAL NEEDS

PROVIDER PROGRESS REPORT

Child's Name: _____ **DOB:** ____/____/____ **Age** ____ **Date of testing:** _____

Provider's Name: (print)_____ **Discipline**:_____

Agency (if applicable): **Bridges to Bright Futures** **IFSP Dates:**_____/_____/_____ **to** _____/_____/_____

Authorized Service_____ **Auth. #**_____

In accordance with the Early Intervention contract, the provider must complete a progress report for each child every three
months and when any amendment is requested. (Note: The provider must maintain a copy of the progress report on file.)
COPIES OF ALL REPORTS MUST BE FORWARDED TO THE CHILD'S PARENT(S), ONGOING SERVICE COORDINATOR AND EIOD AT LEAST FIVE WORKING DAYS PRIOR TO ANY IFSP OR AMENDMENT MEETING.

Please check one: **[ ) End note [ ] 6 Month Report [ ] Amendment**

OUTCOMES: (List outcomes which were designated in the IFSP for which you were responsible. Note if they have been **attained**, are **emerging,** or **not achieved**.)

PROGRESS TO DATE: (For child directed services include: major interventions, formal and informal assessments of developmental level, and current status of the child. For family training services indicate if the family feels that the service is meeting their needs.) Indicate what techniques have been taught to the parent(s) or caregiver(s) and incorporated into the family's daily routine. **AN ASSESSMENT SCORE MUST BE INCLUDED IN EVERY 6 MONTH AND AMENDMENT REPORT.**

Assessment Tool Utilized:	**Assessed Levels of Performance:**

RECOMMENDATIONS OF PROVIDER OR TREATMENT TEAM: Please check the appropriate box. If a continuation of services is recommended include information that supports this recommendation. If there is a recommendation for a change in the delivery of services indicate the specific change and provide a rationale. (If appropriate, the Team Leader fills out the recommendations of the team.)

Please check one: [ ] **Discharge** [ ] **Decrease** [ ] **Continue** [ ] **Increase**

I have been informed by my child's therapist and agree that my child is no longer in need of, nor eligible for Early Intervention Services provided by Suffolk County.
Parent's Signature: _____ Date: _____

Justification:

FUNCTIONAL OUTCOMES AND STRATEGIES: List strategies that can be used by parent(s) and service providers to improve this child's development. Indicate all techniques taught to parent(s) and/or caregiver(s) that can be incorporated into the family's daily routine.

Functional Outcomes: **Strategies:**

C.P.T. Codes:

PROVIDER SIGNATURES:

I certify that I have received a copy of this child's IFSP prior to the commencement of services, and that I have provided the above stated services in accordance with the frequency and duration authorized in that IFSP. Additionally, I certify that my responses in this report are an accurate representation of this child's current level of functioning.

Service Provider's Signature: _____ Date: _____/_____/_____
Please Print Name: _____
Service Provider's License or Certification: _____ **#:** _____
If appropriate, Team Leader completes this section:
Present at Treatment Team Meeting:
Team Member: _____ Discipline: _____
Team Member: _____ Discipline: _____
Team Member: _____ Discipline: _____
Team Leader's Signature: _____ Print Name: _____
Team Leader's Discipline: _____ **Date:** _____

AUTHORIZED UNITS—FREQUENCY, DURATION, AND UTILIZATION:

IFSP Authorized Units: _____ **Frequency/Duration:** _____
(Circle days of session) Sun / Mon / Tues / Wed / Thurs / Fri / Sat
# of Units Utilized: _____ **Times of Therapy:** _____
# of Units Not Utilized Due to Child's Illness, Family Vacation, Etc.: _____
# of Units Not Utilized Due to Therapist's Illness, Scheduling, Etc.: _____
# of Units Not Utilized Due to School Calendar: _____