NYEIS Reference #

Progress Report for: (Check One) Discipline:       DATE OF REPORT:

**IFSP Review [ ]** 6 Month [ ] 12 Month [ ]  18 Month [ ]  24 Month [ ] 30 Month [ ] 36 Month [ ] Discharge [ ]  Amendment

(Report due 6 weeks prior to the end of current IFSP)

Current IFSP period from:       to

Child's Name:

Child's DOB:

Parent/Guardian:

Parent/Guardian Phone:

EIOD

EIOD Phone:

OSC Name:

 OSC Agency:

Provider’s Name:

Provider’s Agency:

**SECTION 1 - SERVICES**

Service type:       Frequency       Duration:       Therapist’s Start Date:

\*Did the Initial Visit take place within 30 days of the effective SA Start date? [ ]  Yes [ ]  No – if not what was the reason?

How many sessions were delivered?       How many sessions cancelled by the family?

How many sessions were canceled by the therapist?

If there have been any gaps in service delivery and/or numerous cancellations - describe length and reason(s) for gaps:

Has the family been present for the sessions?

If not, how have you communicated with them?

When parents are not present, who participates in the session?

**SECTION 2 – IFSP FUNCTIONAL OUTCOMES & STRATEGIES** What IFSP outcome(s) have you been addressing?; Progress towards

IFSP Outcomes (Be specific – list outcome(s) - present levels of performance in relation to the outcome(s); observations; strengths/concerns, etc.)

*RATE OF PROGRESS FOR THIS TIME PERIOD*

|  |  |  |
| --- | --- | --- |
| No Little Moderate | Great Deal | Outcome |
| Progress Progress Progress | Of Progress | Achieved |

 [ ]  [ ]  [ ]  [ ]  [ ]

IFSP OUTCOME (S):

How did you work with the family/caregiver to help the child reach this outcome (list specific strategies)?

*RATE OF PROGRESS FOR THIS TIME PERIOD*

|  |  |  |
| --- | --- | --- |
| No Little Moderate | Great Deal | Outcome |
| Progress Progress Progress | Of Progress | Achieved |

 [ ]  [ ]  [ ]  [ ]  [ ]

IFSP OUTCOME (S):

How did you work with the family/caregiver to help the child reach this outcome (list specific strategies)?

*RATE OF PROGRESS FOR THIS TIME PERIOD*

|  |  |  |
| --- | --- | --- |
| No Little Moderate | Great Deal | Outcome |
| Progress Progress Progress | Of Progress | Achieved |

 [ ]  [ ]  [ ]  [ ]  [ ]

IFSP OUTCOME (S):

How did you work with the family/caregiver to help the child reach this outcome (list specific strategies)?

What have been the successes or challenges of integrating suggested strategies/activities into the child’s daily routine?

 **SECTION 3**

 List any factors that limit the collaboration between parent/caregiver and therapist. How have you addressed the factors

 (be specific)?

How is this helping the family/child to function in their environment in a typical day?

 1. Please list dates of Collaborative Discussions with Provider AND On-Going Service Coordinator:

Required collaborative activities:

|  |  |  |
| --- | --- | --- |
| **Date of Discussion** | **Name of Provider** | **On-Going Service Coordinator** |
|       |       |       |
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**SECTION 4 – CURRENT FUNCTIONING -** **-** Based on your on-going assessment of the child’s progress, please describe the current level(s) of functioning.

What skills is the child unable to perform that are expected at his/her current chronological age? How does this affect their daily functioning?

If assistive technology is being used, what are you using, how are you/other team members using it?

**SECTION 5**

Recommendations (include here any new IFSP outcomes, or changes in strategies and activities.)

Is the child receiving non-EI Services or participating in any community activities?

Does the family wish to participate in community activities and if yes did the team provide information and/or support to facilitate the participation?

**DISCHARGE DATE:**

Parental Consent to Discharge:

 Parent Signature Date

I certify that I have provided the services above in accordance with the frequency and duration mandated by the IFSP, and have worked toward addressing the relative outcomes set forth in the IFSP. I certify that my responses in this report are an accurate representation of the child’s current level of functioning. I further certify that I have acted within the scope of my professional practice.

Provider Signature Date

License &/or Certificate No.

(Where applicable - must be countersigned by appropriate supervisor – OTR/SLP/PT)

Under the direction of:

License #:

Supervisor’s Signature: Date: