SUFFOLK COUNTY DEPARTMENT OF HEALTH
DIVISION OF SERVICES FOR CHILDREN WITH SPECIAL NEEDS
APPLIED BEHAVIOR ANALYSIS TEAM LEADER PROGRESS REPORT

Discharge Report ☐ Date of Discharge: _____

Child's Name: _____ DOB: _____
IFSP Period: From: _____ To: _____ Auth#: _____
Provider: _____ Provider Frequency/Duration: _____
Agency: _____ Provider Start Date: _____
EIOD: _____ OSC: _____
Have there been any gaps in services or frequent service disruptions? (3 or more consecutive missed sessions or frequent cancellations) ☐YES ☐NO If yes, describe the length and the reason(s):

IFSP FUNCTIONAL OUTCOMES (Rate each IFSP goal with **NP**-no progress **LP**-limited progress **GP**-good progress **OA**-outcome achieved)

GOAL:

☐NP ☐LP ☐GP ☐OA

DESCRIBE THE CHANGES SINCE THE LAST REPORT/IFSP:

GOAL:

☐NP ☐LP ☐GP ☐OA

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☐NP ☐LP ☐GP ☐OA

DESCRIBE THE CHANGES SINCE THE LAST REPORT/IFSP:

SUFFOLK COUNTY EARLY INTERVENTION PROGRESS REPORT

Child's Name: _____ DOB: _____

CURRENT LEVEL OF FUNCTIONING Provide an assessment of the child's current level of skills in the 5 domains. Assessment should include observations by the IFSP team, summary of ABA program specific data, clinical opinion and may include standardized testing. Discuss the child's response to therapy.

COLLABORATION Describe all collaborative efforts made to address the IFSP outcomes. Examples: communication with other EI providers, day care staff, other caregivers, community resources, communication notebook, or interactions with medical providers (if other than IFSP team, written consent is necessary).

RECOMMENDATIONS OF THE IFSP TEAM List suggested IFSP goals to target in the next 6 months. Include family priorities.

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: _____ Credentials:_____

Date: _____ Cell phone #_____

Signature of Supervisor/Reviewer: _____ Date:_____