SUFFOLK COUNTY DEPARTMENT OF HEALTH
DIVISION OF SERVICES FOR CHILDREN WITH SPECIAL NEEDS
FAMILY TRAINING 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):

Family/Caregiver Plan:

a. Specific suggestions/recommendations for family/caregiver to facilitate attainment of goals:

b. Describe family/caregiver involvement:

c. Recommendation for future goals: Include family's current priorities and concerns.

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: _____