NASSAU COUNTY DEPARTMENT OF HEALTH EARLY INTERVENTION PROGRAM

APPLIED BEHAVIORAL ANALYSIS TEAM LEADER PROGRESS REPORT FAMILYTRAINING

Discharge Report □

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: Number of units not utilized due to:

Family cancellation: Therapist cancellation:

Date of Discharge (if applicable)

**Family/Caregiver Plan:**

1. *Specific suggestions/recommendations for family/caregiver to facilitate attainment of goals:*
2. *Describe family/caregiver involvement:*
3. *Recommendation for future goals:*

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: Cell phone # License #

Signature of Supervisor/Reviewer: Date :

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